The Basics of Essential Health Benefits

The Essential Health Benefits (EHB) provision of the Affordable Care Act of 2010 (ACA) created 10 general categories of benefits:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Laboratory services
- Maternity and newborn care
- Mental health and substance abuse services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

5 Key Things to Know About Essential Health Benefits

1. EHB includes the 10 mandated categories, with children's dental and vision the only new category typically not covered by UnitedHealthcare medical plans today. State definitions of EHB will vary and may require product adjustments.

2. Most Small Group (insured) and Individual policies will have to cover all EHB categories in 2014, while Large Group (insured and ASO) and all grandfathered plans are not required to cover EHB.

3. Although not all plans have to cover EHB, all plans that do contain any EHB must remove annual dollar and lifetime dollar limits for those services, including Large Group (insured and ASO). Individual grandfathered plans must remove lifetime dollar limits, but not annual dollar limits. With respect to EHB, we already removed lifetime dollar limits and annual dollar limits in 2010. We will continue to make any adjustments required as a result of each state's determination of EHB.

4. The pricing impact of EHB is uncertain because it will depend on state-specific EHB definitions and how much flexibility federal rules will permit.

5. "Habilitative services" are not typically covered explicitly and not yet defined by the states or the Department of Health and Human Services, but are generally provided at parity with rehabilitative benefits.

The content provided is for informational purposes only and does not constitute medical advice. Decisions about medical care should be made by the doctor and patient. Always refer to the plan documents for specific benefit coverage and limitations or call the toll-free member phone number on the ID card.

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