Government of the District of Columbia
Vincent C. Gray, Mayor
Department of Insurance, Securities and Banking

William P. White
Commissioner

District of Columbia Department of Insurance, Securities, and Banking

Essential Health Benefits Notice for Carriers

Revised - May 10, 2013

Note to Carriers: This notice was developed as a resource for carriers for product design purposes and to promote compliance with the Affordable Care Act (ACA) essential health benefits requirements. This notice is offered to assist carriers but may be subject to change; accordingly, it is not binding on the District of Columbia Department of Insurance, Securities, and Banking (DISB), the District of Columbia Health Benefits Exchange (DCHBX), or the federal Department of Health and Human Services (HHS). This notice should not be used exclusive of other important resources, including, but not limited to, any and all other applicable District and federal insurance laws and associated rules and regulations. It is the responsibility of carriers to verify that their products comply with all relevant statutory and regulatory requirements.

ACA requires that all non-grandfathered individual and small group health insurance plans sold in the District of Columbia, beginning January 1, 2014, cover certain delineated essential health benefits (EHBs). In a 2011 bulletin and a final rule released in February of 2013, HHS provided states and the District the option to choose a plan from a range of existing health insurance plans to serve as the EHB benchmark plan, which ultimately defines the standard set of benefits that must be covered by plans in the individual and small employer markets in each state and the District.

The DISB developed this notice in response to carrier requests to provide additional information on the benefits included in the above mentioned benchmark plans. The Attachment to this notice identifies the ten required EHB categories as well as the varying benefits and services that fall within them. These benefits and services must be specifically addressed in all non-grandfathered individual and small group health plans sold in the District of Columbia on or after January 1, 2014. Because EHBs are based on 2012 plan designs, some policy provisions of the EHB-benchmark plan may need to be redesigned to comply with new requirements and limitations for plan years beginning on January 1, 2014.

If you have any questions regarding this notice, please contact Andre Beard at andre.beard@dc.gov or (202)442-7847.

District of Columbia
Illustration of Total Essential Health Benefits (Updated 5/3/2013)
Grouped into the 10 categories of Essential Health Benefits required by the ACA

Benefit	Coverage Details
1. Ambulatory Patient Services	
a. Outpatient hospital facility services	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
b. Ambulatory surgical facility services	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
c. Professional medical services provided at care facility	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
d. Professional surgical services provided at care facility	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
e. Therapeutic services- outpatient intravenous infusion therapy and radiation oncology dialysis	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
f. Surgical procedures- outpatient and diagnostic (not preventive) colonoscopy, sigmoidoscopy, endoscopy	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
g. Outpatient X-rays and major diagnostics, including MRI, MRA, and nuclear medicine	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
h. Pharmaceutical products administered in an outpatient setting	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
i. Office visits for illness (non-preventive) and specialty	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
j. Dialysis	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)

Benefit	Coverage Details
k. Allergy injections	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
l. Office visit (non-routine, non-preventive) OB/GYN	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
m. Speech therapy	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
n. Urgent care (after hours and urgent care center)	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
o. Therapeutic Services- Chemotherapy Electroshock therapy Radiation therapy	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
p. Blood, blood products and administration	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
q. Home health services (limited to 90 visits up to 4 hours per episode of care)	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
2. Emergency Coverage	
a. Emergency room services (including voluntary HIV test performed while receiving emergency medical services at a hospital ER)	Covered In & Out 100% of allowed benefit minus $50 member copay per visit
b. Ambulance service	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
3. Hospitalization	
a. Inpatient facility services (medical or surgical condition)	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
b. Hospitalization for rehabilitation (limited to 90 days per benefit period)	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)

Benefit	Coverage Details
c. Inpatient professional medical services	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
d. Inpatient professional surgical services	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
e. Anesthesia services	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
f. Hospice services (Limited to max 180 day hospice eligibility period)	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
g. Skilled nursing facility services (Limited to max 60 days)	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
h. Transplant Services	Covered CF notes "benefits are available to the same extent as benefits provided for other services."
4. Maternity/Newborn Care	
a. Pre-natal care	Covered CF notes "benefits are available to the same extent as benefits provided for other services."
b. Post-natal care	Covered CF notes "benefits are available to the same extent as benefits provided for other services."
c. Labor and Delivery	Covered CF notes "benefits are available to the same extent as benefits provided for other services."
d. Inpatient Facility Services (48 hours following a vaginal delivery, 96 hours following a Cesarean section)	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
e. Routine newborn care	Covered CF notes "benefits are available to the same extent as benefits provided for other services."
f. Postpartum home visits	In & out 100% of allowed benefit
5. Mental Health, Substance Use Disorders, Behavioral Health Treatment	
a. Mental health outpatient services	Covered in & out Visits 1-40 covered 75% of allowed benefit. Visits 40+: covered 60% of the allowed benefit

Benefit	Coverage Details
b. Substance abuse outpatient services	Covered in & out Visits 1-40 covered 75% of allowed benefit. Visits 40+: covered 60% of the allowed benefit
c. Medication management office visits	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
d. Inpatient mental health facility services (limited to 60 days per benefit period)	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
e. Inpatient mental health professional services	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
f. Inpatient substance abuse facility services (limited to 60 days per benefit period)	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
g. Inpatient substance abuse professional services	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
h. Detoxification- Limited to 12 visits (inpatient or outpatient) per benefit period	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
i. Partial hospitalization	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
6. Prescription Drugs	
a. Preferred preventive drugs	Covered
b. Generic Drug	Covered
c. Preferred brand name drug	Covered
d. Non-preferred brand name drug	Covered
e. Diabetic supplies	Covered
f. Smoking cessation drugs	Covered (prescription only)
g. Oral chemotherapy drugs	Covered

Benefit	Coverage Details
h. Injectable, self-administered medications	For each (34) day supply of covered injectable meds that are self-administered, except for insulin, the Member will be required to pay 50% of Allowed Benefit up to a Member maximum Copay of $75 per covered injectable medication. For up to (90) day supply of self-administered, injectable Maintenance Drugs, except for insulin, the Member will be required to pay 50% of the Allowed Benefit up to a Member maximum payment of $150.
i. Prescription drugs (general)	For Prescription Drugs purchased in a Pharmacy or purchased through the mail order program, there is one Copayment due for each thirty-four (34) day supply.
j. Maintenance drugs (general)	For Maintenance Drugs, a Member may receive up to a ninety (90) day supply provided the Member pays one Copayment for the first thirty-four (34) day supply and a second Copayment for a supply of thirty-five (35) days or more.
k. Contraception	Covered
7. Rehabilitative & Habilitative Services and Devices	
a. Rehabilitation Services (occupational therapy, physical therapy, speech therapy)	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
b. Spinal manipulation services (limited to 12 years and older)	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
c. Habilitative services (for all ages, including Applied Behavioral Analysis for autism)	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
d. Cardiac rehabilitation (90 days)	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
e. Pulmonary rehabilitation (limited to 1 program per lifetime)	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
f. Internal prosthetics	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)

Benefit	Coverage Details
g. External prosthetics- breast prostheses, mastectomy bras	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
h. Durable medical equipment (DME)	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
8. Laboratory Services	
a. Laboratory tests	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
b. X-rays and other diagnostic procedures	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
9. Preventive and Wellness Services	
a. Adult routine physical exam	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
b. Routine gynecological exam	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
c. Prostate cancer screening	In & out 100% of allowed benefit
d. Pap smear	In & out 100% of allowed benefit
e. Mammography	In & out 100% of allowed benefit
f. Colorectal cancer screening	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
g. Immunizations	In & out 100% of allowed benefit
h. Medical nutrition therapy	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
i. Professional nutritional counseling	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
j. HPV screening	Covered

Benefit	Coverage Details
k. Diabetes treatment	Covered In- 100% of allowed benefit Out- 80% of allowed benefit (Deductible Out only)
10. Pediatric Services, including Oral and Vision	
a. Well-child care	In & out 100% of allowed benefit
b. Preventive services for obesity	In & out 100% of allowed benefit
c. Vision- eye exam (separate visit)	1 per year
d. Vision- lenses	1 pair per year
e. Vision- frames	1 per year ($150 allowance)
f. Vision- contact lenses	1 per year ($150 allowance, $600 for medical necessity)
g. Routine exams/evaluations (including cleanings, fluoride treatment, and bitewing x-rays	Every 6 months (100%)
h. Sealants	Every 3 years, per molar
i. Dental class B-Intermediate: filings and periodontal maintenance	Covered (70%)
k. Dental class C- Major: crowns, bridges, root canal treatment and dentures	Covered (60%)
l. Dental class D- Orthodontia: comprehensive orthodontic treatment, fixed appliance	Covered (50%)