

# What Are the ACA Essential Health Benefits?

By [Beth Braverman](#) | Updated on: January 21st, 2021 | Reviewed by [Kim Buckey](#)

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Why Trust Our Content?

The Affordable Care Act requires that certain health insurance plans include coverage for 10 "essential health benefits." Those covered benefits include hospital services, prescription drugs, pregnancy care, and [childbirth](#).<sup>1</sup>

The requirements apply only to plans available in the Marketplace and to fully insured small group and individual plans. While self-insured and large-group plans are exempt from this requirement, most have also adopted the essential health benefits and share the cost of those benefits with their employees.<sup>2</sup>

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Before the [Affordable Care Act \(ACA\)](#) was implemented in 2014, health plans available on the individual market often excluded certain types of coverage, including maternity care, substance abuse treatment, and mental health.

That made it more difficult or more expensive for many people to buy health insurance on their own. They discovered too late that their plan wouldn't pay for the care they needed or that they had to pay huge [premiums](#) for insurance that would cover their pre-existing conditions.<sup>3</sup> The Affordable Care Act also requires that insurers provide coverage to anyone, regardless of [preexisting health conditions](#).

### What You Need to Know

- Under the Affordable Care Act all small group and individual health insurance plans must cover 10 essential health benefits.
- The level of coverage of those benefits varies, based on each state's benchmark plan.<sup>4</sup>
- Insurers cannot impose an annual dollar limit or lifetime maximum on essential health benefits.<sup>5</sup>

### What Are the 10 Essential Health Benefits?

- Ambulatory patient services.** This is the outpatient care, from doctor's visits to same-day surgery, that you receive without being admitted to a hospital.
- Emergency services.** Insurance companies cannot charge you more for going to an out-of-network hospital's emergency room in the case of a true emergency, such as a suspected heart attack or stroke,<sup>6</sup> nor can they require prior approval for emergency room visits.
- Hospitalization.** This benefit includes surgery or other overnight, in-patient stays at a hospital.<sup>7</sup>
- Pregnancy, maternity, and newborn care.** Insurance must cover medical services for you and your child, both before and after birth, as well as the cost of the delivery itself. Insurers must also cover birth control and breastfeeding services.<sup>8</sup>
- Mental health and substance use disorder services.** Behavioral health treatment, such as counseling or psychotherapy, is a part of this benefit.<sup>9</sup>
- Prescription drugs.** While insurers don't cover all drugs, they must offer a formulary (approved list of medications) for which they'll pay a portion of the costs.<sup>10</sup> The government has categorized approved drugs, and insurers must cover at least one drug from each category. You can find a list of the medicines that your insurer covers by visiting its website.
- Rehabilitative and habilitative services and devices.** This benefit includes devices or services aimed at helping people with chronic conditions, disabilities, or injuries regain or improve skills.<sup>11</sup>
- Laboratory services.** Coverage includes tests that doctors might run to aid in diagnosis.<sup>12</sup>
- Preventive and wellness services and chronic disease management.** Preventive and wellness care covers routine doctor's visits, such as annual exams and vaccinations. If you get preventive health services, such as a pap test, from an in-network provider, their services are free.<sup>13</sup> However, not every service that you receive at a checkup is covered, so check your benefits before you go.
- Pediatric services.** In addition to the above benefits, children's benefits must include vision and dental care.<sup>14</sup>

### Did You Know?

All 10 benefits are covered in every state, but the extent of coverage varies.

### Do Essential Health Benefits Vary from State to State?

Each state has a "benchmark plan," which sets the standards for the minimum level of coverage that all plans must offer and determines which services in each category get covered. While the exact services and cost-sharing arrangements vary, state benchmark plans mandate coverage at the level of a "typical employer plan."<sup>15</sup>

This means that all 10 benefits are covered in every state, but the extent of coverage varies. [Kansas'](#) benchmark plan, for example, covers 20 visits per year for speech rehabilitation, while [Wisconsin's](#) plan covers 90.<sup>16</sup>

Other states may have slightly different formularies, which means they cover a different set of prescription drugs. While the essential health benefits are the minimum, many plans offer coverage that goes beyond these requirements.

From 2017 to 2019, a state's benchmark plan was a plan sold in that state in 2014.

This year, states have four options:<sup>17</sup>

- Maintain their benchmark plan from 2017.
- Use another state's benchmark plan from 2017.
- Replace one or more of the required categories with those from another state's plan.
- Create an entirely new benchmark plan.

Since the benchmark plan can change, it's important to review your plan each year to know what's covered.

While many insurance plans offered by large employers cover essential health benefits, they're not required to do so.<sup>18</sup> Employers who offer such plans may not impose an annual or lifetime cap on those benefits, but annual or lifetime limits are allowed on benefits that do not fall into the 10 categories of essential health benefits.

Employers who self-insure can choose any state's benchmark as a guide for the benefits they offer. Employers with insured plans must use the benchmark of the state where they are "situated,"<sup>19</sup> which means the state where they are headquartered or where most of their employees live.

### Did You Know?

Insurance plans offered by large employers cover essential health benefits, but they're not required to do so.

### How Are Essential Benefits Covered?

Once you've hit the out-of-pocket limit (excluding premiums) for the year for essential health benefits, your health plan will cover 100% of the cost of those benefits. The out-of-pocket maximum for 2020 is \$8,150 for individuals and \$16,300 for families. For 2021, the limits are \$8,550 for individuals and \$17,100 for families.<sup>20</sup>

It's important to understand essential health benefits in order to make the most of your health insurance plan. Still, even if your plan covers these benefits, your premiums and [copayments](#) may vary, so it's important to take a close look at the details of your existing plan.

### Next Steps

Knowing about essential health benefits can also make it easier to choose a new health insurance plan if you're purchasing an [Obamacare plan](#). The [best plan for you](#) depends on your health, your financial circumstances, and the services provided by a specific plan. If you're purchasing a plan via the marketplace, you may be eligible for a [subsidy](#) to offset the premiums, depending on your income.

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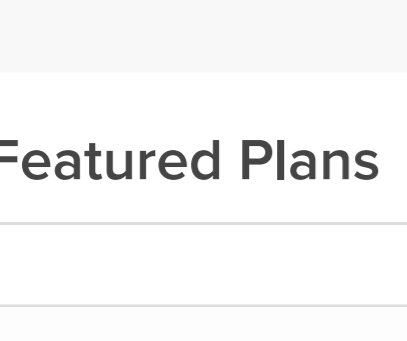
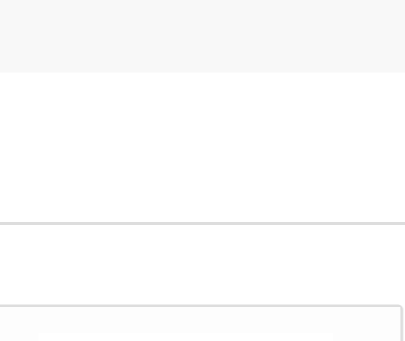

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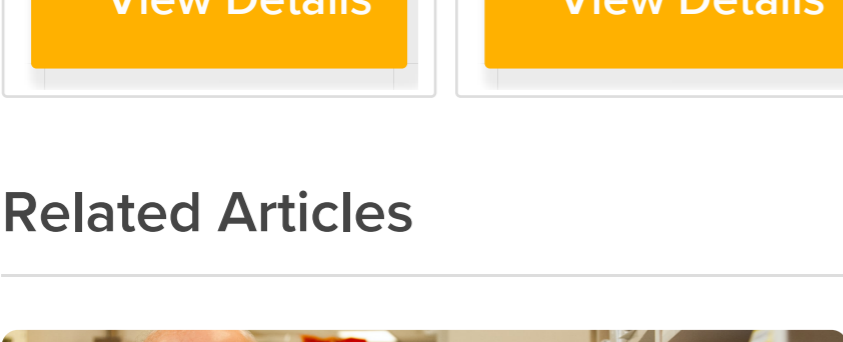
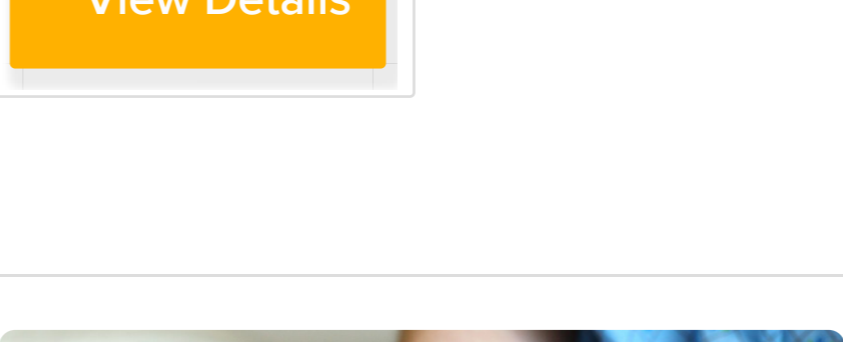
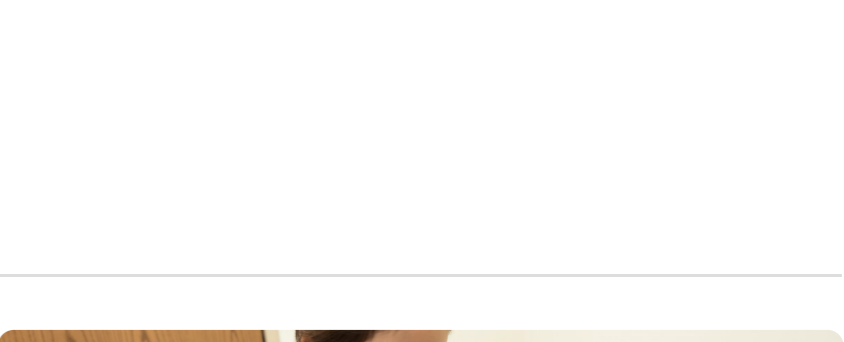
Beth Braverman is a full-time journalist covering personal finance, healthcare, and careers. A former reporter for MONEY magazine, her work has appeared in dozens of publications, including CNBC.com, CNNMoney.com, and WebMD.

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