



**BlueCross BlueShield
of Illinois**

**Frequently Asked Questions (FAQs)
EHB Out-of-Pocket Limits
Updated May 28, 2013**

Q1. What benefits are considered essential health benefits (EHBs)?

EHBs include services and items across these 10 essential health benefit categories.

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance abuse disorder services, including behavioral health treatment
6. Prescription drugs
7. Habilitative and rehabilitative services and devices
8. Laboratory services
9. Preventive and wellness services, and chronic disease management
10. Pediatric services

Insured small group plans and individual plans that are non-grandfathered must cover EHBs in 2014. This applies whether these plans are sold in or outside of the exchange (also known as the Health Insurance Marketplace). The minimum package of items and services that must be covered in each of these health benefit categories is generally defined by each [state's EHB benchmark plan](#).

Q2. Which plans must cap out-of-pocket expense for EHBs in 2014?

Non-grandfathered plans that cover essential health benefits (EHBs) must cap member out-of-pocket expenses for EHBs (in-network) for plan years beginning on or after Jan. 1, 2014.

Q3. How will large, self-insured and grandfathered plans define EHBs for the purpose of meeting cost-sharing requirements?

Until now, self-funded plans and carriers like BCBS were allowed to use "good faith" definitions to comply with the ban on dollar limits for EHBs. However, the government has indicated an "authorized definition" of EHBs will be needed to comply with the cost-sharing requirements in the future. At this point, it's unclear whether the "good faith" definition will stand as an HHS "authorized" definition for 2014 plan years. We are actively working to clarify details on this point.

Q4. Would the state EHB benchmark plans serve as an "authorized definition" for large, self-insured and grandfathered plans?

The state EHB benchmark plans define the items and services that must be covered as essential health benefits for non-grandfathered individual and non-grandfathered, fully-insured plans in 2014. However, it is not clear whether these benchmark plans will work as an "authorized definition" for large, self-insured and grandfathered plans in 2014.

Q5. What types of member expenses must be applied toward the out-of-pocket maximum?

The following types of member expenses must apply to the out-of-pocket maximum:

- ✓ Deductibles for EHBs (in-network)
- ✓ Coinsurance for EHBs (in-network)
- ✓ Copayments for EHB (in-network)
- ✓ Other EHB expenditure required by, or on behalf, of an enrollee (in-network)



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Q6. What types of member expenses would not be part of the out-of-pocket maximum?

- Cost-sharing (i.e., deductibles, coinsurance and copayments) for out-of-network benefits (for network plans)
- Balance billing for out-of-network providers
- Premiums
- Expenditures required by, or on behalf, of an enrollee for non-covered services

Q7. How does the out-of-pocket maximum work when essential health benefits are carved out to (administered by) more than one service provider?

Each service provider can independently calculate and maintain separate out-of-pocket maximums -- as long as the total does not exceed ACA's annual out-of-pocket cap on member expenses for essential health benefits for 2014 (\$6,350 individual and \$12,700 family as established by the IRS). However, medical/surgical and mental health/substance abuse disorder benefits must be calculated and maintained together to meet federal mental health parity requirements.

Example
Out-of-Pocket Caps for EHBs Administered by Multiple Service Providers
No safe harbor

Service provider/Benefits administered	Individual out-of-pocket limit	Family out-of-pocket limit
Service Provider A /Medical Includes mental health and substance abuse	\$4,100	\$8,200
Service Provider B/Pediatric Dental	\$700	\$1,400
Service Provider C /Pharmacy	\$1,550	\$3,100
TOTAL*	\$6,350	\$12,700

* Cannot exceed ACA's out-of-pocket cap for essential health benefits.
There are exceptions under a [safe harbor](#).

Q8. What are the details of the safe harbor related to EHB out-of-pocket limits?

The safe harbor for the 2014 plan year allows each service provider to calculate and maintain separate out-of-pocket maximums (OOPM) - as long as the OOPM for each service provider does not exceed the IRS out-of-pocket limits for high deductible health plans (HDHP) for 2014 of \$6,350 individual and \$12,700 family. Medical/surgical and mental health/substance abuse disorder benefits must be calculated and maintained together to meet federal mental health parity requirements.

Example
Out-of-Pocket Caps for EHBs Administered by Multiple Service Providers
With the Safe Harbor in 2014

Service provider/Benefits administered	Individual out-of-pocket limit	Family out-of-pocket limit
Service Provider A /Medical Includes mental health and substance abuse	\$6,350	\$12,700
Service Provider C /Pharmacy	\$6,350	\$12,700
TOTAL	\$12,700	\$25,400



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Q9. How does the safe harbor from the EHB out-of-pocket requirement work?

Each individual service provider that administers EHB benefits can maintain its own out-of-pocket (OOP) cap up to \$6,350 individual /\$12,700 family for the 2014 plan year.

If a group health plan uses multiple service providers to administer its essential health benefits, it is eligible for the safe harbor under the following conditions:

- The plan's "major medical coverage" cannot exceed ACA's OOP cap.
- Member out-of-pockets for essential health benefits beyond major medical cannot exceed ACA's OOP cap. For example a group with prescription drug coverage must limit the member's out-of-pocket expenses for these benefits to the ACA cap.
- Member out-of-pockets for medical/surgical and mental health/substance use disorder benefits must still cross-accumulate up to single OOP as required under federal mental health parity law.

Q10. There are also deductible limits. Do all plans have to cap deductibles on EHBs?

Not at this time. It appears that the deductible cap only applies to non-grandfathered fully insured small group plans in 2014. However, this is subject to future rulemaking from the federal government.

This information does not constitute legal or tax advice and it may be subject to change. Please consult your summary plan description (SPD)/benefit booklet for the specific terms and conditions of your coverage.