Draft CORE Eligibility & Benefits Data Content Rule Package
Updates at-a-glance

CORE Eligibility & Benefits (270/271) Data Content Rule Updates to Review

The CORE Eligibility & Benefits Operating Rules increase transparency of benefit coverage for patients and providers prior to service. These rules ensure that financial details—such as co-insurance, co-payment, deductible, and remaining deductible amounts—are provided along with coverage information across a defined set of service types and procedure codes.

The current version of the rule, vEB.2.0 (updated in April 2022), is being enhanced with the proposed vEB.2.1 update. These updates support the industry's evolving needs by providing even more comprehensive coverage information for medication eligibility and dental use cases.

Draft CORE Eligibility & Benefits Data Content Rule Package Changes

- UPDATED: Draft CORE Eligibility & Benefits (270/271) Data Content Rule vEB.2.1
- NEW: Draft Appendix for CORE Eligibility & Benefits (270/271) Data Content Rule vEB.2.1

Applicable X12 Submission Methods

- X12 005010X279 270 Health Care Eligibility/Benefit Inquiry Transaction
- X12 005010X279 271 Health Care Eligibility/Benefit Response Transaction

Requirement Area	Current Rule vEB.2.0	Proposed Draft Rule vEB.2.1

CORE-required Service Type Codes (STCs)	Response across 178 STCs must include:
	- Health Plan Name
	- Eligibility Dates
	- Status of Coverage
	- Patient Financial Responsibility:
	  - Deductible
	  - Co-payment
	  - Co-insurance
	  - Base Deductible Date
	- Telemedicine Benefits
	- Prior Authorization and Referral Determination
	- Maximum & Remaining Coverage Benefits (for 10 STCs such as Physical Therapy, Occupational Therapy)
		Expands required maximum and remaining coverage benefits to 30 STCs, adding pharmacy, experimental drug therapy, orthodontics, various dental services, emergency services, anesthesia, etc.

Procedure Code Types	Must support the following procedure code types if they align with listed COS: - HCPCS - CPT	Expands procedure code types to include: - HCPCS (including J-Codes) - National Drug Codes (NDCs) - Current Dental Terminology (CDT) - ICD-10-PCS

Requirement Area	Current Rule vEB.2.0	Proposed Draft Rule vEB.2.1

Categories of Service (COS)	Procedure code-level responses across 4 COS (Physical Therapy, Occupational Therapy, Imaging, and Surgery) must include:
	- Health Plan Name
	- Eligibility Dates
	- Status of Coverage
	- Patient Financial Responsibility:
	  - Deductible
	  - Co-payment
	  - Co-insurance
	  - Base Deductible Date
	- Prior Authorization and Referral Determination
		Expands COS response requirements to include 29 additional COS to support medication eligibility and dental benefit coverage determination, such as:
		- Oncology
		- Pain Management
		- Radiology
		- Preventative Care
		- Specialty Procedures
		- Internal Medicine
		- Maternal Health, and more.

Tiered Benefits	Provides granular data for members of tiered benefit plans and provider tier network status	No change to tiered benefits requirement.
Dental Specific Limitations	Not specified in vEB.2.0	For dental-related COS, responses must include the following as applicable: - Frequency Limitations - Waiting Periods - Age Limitations - Maximum and Remaining Coverage Benefits
Plan-Specific Requirements	Not specified in vEB.2.0	Health plans must post any plan-specific requirements for the Eligibility & Benefits transaction online in an easily accessible location.