DC HBX STANDARD PLAN WORKING GROUP
$5 COPAY RECOMMENDATION
FOR PEDIATRIC MENTAL HEALTH COST SHARING FOR STANDARD PLANS

1. **Mental Health Services and Medications with Modified Cost Sharing**
   For ALL mental health conditions.
   - Includes all primary diagnosis codes beginning with F (not secondary or lower), see ICD-10 CM online at Comprehensive Listing ICD-10-CM Files (cdc.gov)
   - For visits, we are not differentiating between visit types for initial assessments, medical evaluation and management visits, and follow-up therapy visits. We have CPT codes that correspond to all visit types and all modalities, e.g., telehealth.

2. **Ages Covered**
   Up to 19th birthday, consistent with pediatric ACA services.

3. **Cost-Sharing with AV Offset:**

$5 Copay for All Services (including drugs and labs)

Plan	Current Metal AV	Age 18, $5 Copay
Platinum Plan 2023	89.89%	89.92%
Gold Plan 2023	81.92%	81.91%
Silver Plan 2023	71.95%	71.95%
Bronze Copay Plan 2023	64.91%	65.00%

AV Offset

	MOOP – Current	MOOP – Adjusted
Gold - $5 Copay	$5,800	$5,900
Silver - $5 Copay	$8,850	$9,100

4. **Bronze HSA Plan**
   No modification to Bronze HSA plan (which must comply with federal law).

5. **Compliance with Federal Law**
   All modifications are conditioned on compliance with applicable federal laws. HBX will work with carriers to ensure compliance.

UNIFIED TREATMENT SCENARIO FOR ADDRESSING MENTAL HEALTH CONDITIONS AMONG CHILDREN IN DC

For encounters with All ICD-10 F codes (all mental health conditions) among patients up to 19th birthday:

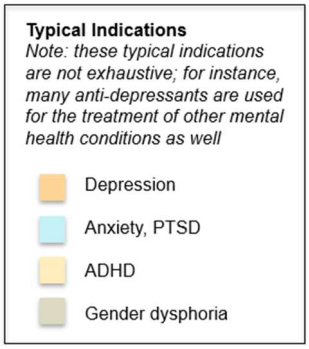
VISIT TYPES	CPT CODES	SERVICE TYPES	SPECIALTY	DESCRIPTION OF INCLUDED SERVICES
New, Follow up	11981 90835 90836 90837 90838 90839 90840 90846 90847 90853 96127 99202 99203 99204 99205 99211 99212 99213 99214 99215 99244 99245 99354 99355 99442 99443 99484 99492 99493 99494	Primary Care, Mental Health Care	Behavioral Health/Psychiatry; Internal Medicine/Infectious Disease/Family Medicine/Gynecology/Endocrinology	New medical visit; New patient, screening/assessment; Evaluation and management; Psychotherapy crisis; Individual therapy; Family/Group therapy

Related services for gender dysphoria only:

RELATED SERVICES TO BE COVERED WITH ZERO COST SHARING		CPT CODE
Laboratory Tests	Testosterone (free and total)	84402, 84403
	Estradiol	82670, 30289
	Hemoglobin and hematocrit (or complete blood count)	85014, 85018, 85025
	Comprehensive metabolic panel	80053
	25 OH-D Vitamin D	82306
	Lipid panel	80061
	Luteinizing hormone and follicle-stimulating hormone	83001, 83002
	Prolactin	84146
Imaging	DEXA scan	77080
	Bone age x-ray	77072
Procedures	Hormone therapy injection	96372

Medications (developed based on treatment of most prevalent mental health conditions, but not limited to use with these conditions: anxiety, PTSD, depression, gender dysphoria, ADHD, Autism, and conduct disorders among patients 18 years of age and under). Not all drugs in a class are required to be covered at the lower cost sharing level. Additionally, a carrier is not required to change the drugs that are on the carrier's formulary.

MEDICATION CLASS/GROUP	SPECIFIC MEDICATIONS TO BE COVERED WITH ZERO COST SHARING
SSRIs	All
SNRIs	All
Atypical antidepressants	All (e.g., SARIs, mirtazapine, trazodone)
Anti-hypertensives	Prazosin
Atypical anxiolytics	All (e.g., buspirone)
Alpha agonists	Clonidine, Clonidine ER, Guanfacine, Guanfacine ER
Beta blockers	Propranolol
Anti-manic agents	All (e.g., lithium)
Stimulants	All (e.g., amphetamine, methylphenidate)
Anti-psychotics	Quetiapine, Aripiprazole, Brexpiprazole, Lurasidone
GnRH analogs	All (e.g., Lupron, Triptorelin, Histrelin)
Sex hormones	All (e.g., oral/transdermal/injectable estradiol, injectable/transdermal testosterone, progesterone)
Nonsteroidal anti-androgens	All (e.g., bicalutamide, spironolactone)
5-alpha reductase inhibitors	All (e.g., finasteride, dutasteride)



D.C. Health Benefit Exchange
Standard Plans Advisory Working Group
Platinum Plan 2024***

Actuarial Value			89.92%	
Individual Overall Deductible			$0	
Other individual deductibles for specific services				
Medical			$0	
Prescription Drugs			$0	
Dental			$0	
Individual Out-of-Pocket Maximum			$2,000	
Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health Care Provider's Office or Clinic visit*	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$20	
	Specialist visit		$40	
	Preventive care/screening/immunization		$0	
Tests	Laboratory tests**		$20	
	X-rays and diagnostic imaging		$40	
	Imaging (CT/PET scans, MRIs)		$150	
Drugs to treat Illness or Condition***	Generic		$5	
	Preferred brand		$15	
	Non-preferred Brand		$25	
	Specialty		$100	
Outpatient Surgery	Facility fee (e.g. hospital room)		$250	
	Physician/Surgeon fee			
Outpatient Non-surgical Clinic Visit****	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic		$75	
Need Immediate Attention	Emergency room services (waived if admitted)		$150	
	Emergency medical transportation		$150	
	Urgent Care		$40	
Hospital Stay	Facility fee (e.g. hospital room)		$250 per day up to 5 days	
	Physician/surgeon fee			
Mental/Behavioral Health	M/B office visits		$20	
	M/B outpatient services		$20	
	M/B inpatient services		$250 per day up to 5 days	
Health, Substance Abuse needs	Substance abuse disorder office visits		$20	
	Substance abuse disorder outpatient services		$20	
	Substance abuse disorder inpatient services		$250 per day up to 5 days	
Pregnancy	Prenatal care and preconception services		$0	
	Delivery and all inpatient services	Hospital	$250 per day up to 5 days	
		Professional		

*PCP visits dilated retinal exam (1x per year), diabetic foot exam (1x per year), and nutritional counseling visits (unlimited) with a primary diagnosis of Type 2 diabetes are provided with no cost-sharing.
**For a person with a primary diagnosis of Type 2 diabetes, the following lab services are provided with no cost-sharing:

- Lipid panel test (1x per year)
- Hemoglobin A1C (2x per year)
- Microalbumin urine test or nephrology visit (1x per year)
- Basic metabolic panel (1x per year)
- Liver function test (1x per year)

*** A select list of diabetes supplies and medications within the diabetic agents drug class, as defined by the carrier, are provided with no cost-sharing. A carrier is not required to change the drugs that are on the carrier's formulary.
****Copay may not apply in a staff model HMO setting

	Home health care	$20	
	Outpatient rehabilitation services	$20	
	Outpatient habilitation services	$20	
	Skilled nursing care	$150 per day up to 5 days	
	Durable medical equipment	10%	
	Hospice services	$0	
Child eye care	Eye exam	$0	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive – cleaning	$0	
	Preventive- x-ray	$0	
	Sealants per tooth	$0	
	Topical fluoride application	$0	
	Space Maintainers – Fixed	$0	
Child Dental Basic Services	Amalgam Fill – 1 surface	$25	
Child Dental Major Services	Root canal – molar	$300	
	Gingivectomy per Quad	$150	
	Extraction – single tooth exposed root or	$65	
	Extraction – complete bony	$160	
	Porcelain with Metal Crown	$300	
Child Orthodontics	Medically necessary orthodontics	$1,000	

***** Treatment of mental health conditions for children 18 and under will be provided with $5 cost-sharing as reflected in the Pediatric Mental Health Cost Sharing Treatment Recommendation.

D.C. Health Benefit Exchange
Standard Plans Advisory Working Group
Gold Plan 2024***

Actuarial Value			81.91%	
Individual Overall Deductible			$500	
Other individual deductibles for specific services				
Medical			$500	
Prescription Drugs			$0	
Dental			$0	
Individual Out-of-Pocket Maximum			$5,900	
Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health Care Provider's Office or Clinic visit*	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$25	
	Specialist visit		$50	
	Preventive care/screening/immunization		$0	
Tests	Laboratory tests**		$30	
	X-rays and diagnostic imaging		$50	
	Imaging (CT/PET scans, MRIs)		$250	
Drugs to treat Illness or Condition***	Generic		$15	
	Preferred brand		$50	
	Non-preferred Brand		$70	
	Specialty		$150	
Outpatient Surgery	Facility fee (e.g. hospital room)		$525	
	Physician/Surgeon fee		$75	
Outpatient Non-Surgical Clinic Visit****	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic		$75	
Need Immediate Attention	Emergency room services (waived if admitted)		$300	
	Emergency medical transportation		$300	
	Urgent Care		$60	
Hospital Stay	Facility fee (e.g. hospital room)		$600 per day up to 5 days	X
	Physician/surgeon fee			X
Mental/Behavioral Health	M/B office visits		$25	
	M/B outpatient services		$25	
	M/B inpatient services		$600 per day up to 5 days	X
Substance Abuse needs	Substance abuse disorder office visits		$25	
	Substance abuse disorder outpatient services		$25	
	Substance abuse disorder inpatient services		$600 per day up to 5 days	X
Pregnancy	Prenatal care and preconception services		$0	
	Delivery and all inpatient services	Hospital	$600 per day up to 5 days	X
		Professional		X

*PCP visits, dilated retinal exam (1x per year), diabetic foot exam (1x per year), and nutritional counseling visits (unlimited) with a primary diagnosis of Type 2 diabetes are provided with no cost-sharing.

**For a person with a primary diagnosis of Type 2 diabetes, the following lab services are provided with no cost-sharing:

- Lipid panel test (1x per year)
- Hemoglobin A1C (2x per year)
- Microalbumin urine test or nephrology visit (1x per year)
- Basic metabolic panel (1x per year)
- Liver function test (1x per year)

***A select list of diabetes supplies and medications within the diabetic agents drug class, as defined by the carrier, are provided with no cost-sharing. A carrier is not required to change the drugs that are on the carrier's formulary.
****Copay may not apply in staff model HMO setting.

Help recovering or other special health needs	Home health care	$30	
	Outpatient rehabilitation services	$30	
	Outpatient habilitation services	$30	
	Skilled nursing care	$300 per day up to 5 days	
	Durable medical equipment	20%	
	Hospice services	$0	
Child eye care	Eye exam	$0	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive – cleaning	$0	
	Preventive- x-ray	$0	
	Sealants per tooth	$0	
	Topical fluoride application	$0	
	Space Maintainers – Fixed	$0	
Child Dental Basic Services	Amalgam Fill – 1 surface	$25	
Child Dental Major Services	Root canal – molar	$300	
	Gingivectomy per Quad	$150	
	Extraction – single tooth exposed root or	$65	
	Extraction – complete bony	$160	
	Porcelain with Metal Crown	$300	
Child Orthodontics	Medically necessary orthodontics	$1,000	

***** Treatment of mental health conditions for children 18 and under will be provided with $5 cost-sharing as reflected in the Pediatric Mental Health Cost Sharing Treatment Recommendation.

D.C. Health Benefit Exchange
Standard Plans Advisory Working Group
Silver Plan 2024

Actuarial Value			71.95%	
Individual Overall Deductible			$5,200	
Other individual deductibles for specific services				
Medical			$ 4,850	
Prescription Drugs			$350	
Dental			$0	
Individual Out-of-Pocket Maximum			$9,100	
Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health Care Provider's Office or Clinic visit*	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$40	
	Specialist visit		$80	
	Preventive care/screening/immunization		$0	
Tests	Laboratory tests**		$60	
	X-rays and diagnostic imaging		$80	
	Imaging (CT/PET scans, MRIs)		$400	
Drugs to treat Illness or Condition***	Generic		$20	
	Preferred brand		$50	X
	Non-preferred Brand		$70	X
	Specialty		$150	X
Outpatient Surgery	Facility fee (e.g. hospital room)		20%	X
	Physician/Surgeon fee		20%	X
Outpatient Non-surgical Clinic Visit****	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic		20%	X
Need Immediate Attention	Emergency room services (waived if admitted)		$400	X
	Emergency medical transportation		$400	X
	Urgent Care		$90	
Hospital Stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental/Behavioral Health	M/B office visits		$40	
	M/B outpatient services		$40	
	M/B inpatient services		20%	X
Health, Substance Abuse needs	Substance abuse disorder office visits		$40	
	Substance abuse disorder outpatient services		$40	
	Substance abuse disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception services		$0	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X

*PCP visits, dilated retinal exam (1x per year), diabetic foot exam (1x per year), and nutritional counseling visits (unlimited) with a primary diagnosis of Type 2 diabetes are provided with no cost-sharing.
**For a person with a primary diagnosis of Type 2 diabetes, the following lab services are provided with no cost-sharing:

- Lipid panel test (1x per year)
- Hemoglobin A1C (2x per year)
- Microalbumin urine test or nephrology visit (1x per year)
- Basic metabolic panel (1x per year)
- Liver function test (1x per year)

***A select list of diabetes supplies and medications within the diabetic agents drug class, as defined by the carrier, are provided with no cost-sharing. A carrier is not required to change the drugs that are on the carrier's formulary.
****Coinsurance may not apply in staff model HMO setting.

Help recovering or other special health needs	Home health care	$50	
	Outpatient rehabilitation services	$65	
	Outpatient habilitation services	$65	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
	Hospice services	$0	
Child eye care	Eye exam	$0	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive – cleaning	$0	
	Preventive- x-ray	$0	
	Sealants per tooth	$0	
	Topical fluoride application	$0	
	Space Maintainers – Fixed	$0	
Child Dental Basic Services	Amalgam Fill – 1 surface	$25	
Child Dental Major Services	Root canal – molar	$300	
	Gingivectomy per Quad	$150	
	Extraction – single tooth exposed root or	$65	
	Extraction – complete bony	$160	
	Porcelain with Metal Crown	$300	
Child Orthodontics	Medically necessary orthodontics	$1,000	

***** Treatment of mental health conditions for children 18 and under will be provided with $5 cost-sharing as reflected in the Pediatric Mental Health Cost Sharing Treatment Recommendation.

D.C. Health Benefit Exchange
Standard Plans Advisory Working Group
Bronze Copay Plan 2024***

Actuarial Value		65.00%	
Individual Overall Deductible		$8,350	
Other individual deductibles for specific services			
Medical		$7,500	
Prescription Drugs		$850	
Dental		$0	
Individual Out-of-Pocket Maximum		$9,100	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health Care Provider's Office or Clinic visit*	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$45	
	Specialist visit	$105	
	Preventive care/screening/immunization	$0	
Tests	Laboratory tests**	$55	X
	X-rays and diagnostic imaging	$80	X
	Imaging (CT/PET scans, MRIs)	$500	X
Drugs to treat Illness or Condition***	Generic	$25	
	Preferred brand	$75	X
	Non-preferred Brand	$100	X
	Specialty	$150	X
Outpatient Surgery	Facility fee (e.g. hospital room)	40%	X
	Physician/Surgeon fee	40%	X
Outpatient Non-surgical Clinic Visit****	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	40%	X
Need Immediate Attention	Emergency room services	40%	X
	Emergency medical transportation	40%	X
	Urgent Care	$100	
Hospital Stay	Facility fee (e.g. hospital room)	40%	X
	Physician/surgeon fee	40%	X
Mental/Behavioral Health	M/B office visits	$45	
	M/B outpatient services	$0	
	M/B inpatient services	40%	X
Health, Substance Abuse needs	Substance abuse disorder office visits	$45	
	Substance abuse disorder outpatient services	$0	
	Substance abuse disorder inpatient services	40%	X
Pregnancy	Prenatal care and preconception services	$0	
	Delivery and all inpatient services – Hospital	40%	
	Delivery and all inpatient services – Professional		

*PCP visits, dilated retinal exam (1x per year), diabetic foot exam (1x per year), and nutritional counseling visits (unlimited) with a primary diagnosis of Type 2 diabetes are provided with no cost-sharing.
**For a person with a primary diagnosis of Type 2 diabetes, the following lab services are provided with no cost-sharing:

- Lipid panel test (1x per year)
- Hemoglobin A1C (2x per year)
- Microalbumin urine test or nephrology visit (1x per year)
- Basic metabolic panel (1x per year)
- Liver function test (1x per year)

A select list of diabetes supplies and medications within the diabetic agents drug class, as defined by the carrier, are provided with no cost-sharing. A carrier is not required to change the drugs that are on the carrier's formulary.*Coinsurance may not apply in a staff model HMO setting.

Help recovering or other special health needs	Home health care (up to 90 visits for 4 hours per calendar yr)	$50	X
	Outpatient rehabilitation services	$50	X
	Outpatient habilitation services	$50	X
	Skilled nursing care	30%	X
	Durable medical equipment	30%	X
	Hospice services	30%	X
Child eye care	Eye exam (OD)	$50	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive – cleaning	$0	
	Preventive- x-ray	$0	
	Sealants per tooth	$0	
	Topical fluoride application	$0	
Child Dental Basic Services	Amalgam Fill – 1 surface	$41	
Child Dental Major Services	Root canal – molar	$512	
	Gingivectomy per Quad	$279	
	Extraction – single tooth exposed root or	$69	
	Extraction – complete bony	$241	
	Porcelain with Metal Crown	$523	
Child Orthodontics	Medically necessary orthodontics	$3,422	

***** Treatment of mental health conditions for children 18 and under will be provided with $5 cost-sharing as reflected in the Pediatric Mental Health Cost Sharing Treatment Recommendation.

D.C. Health Benefit Exchange
Standard Plans Advisory Working Group
HSA Bronze Plan 2024

Actuarial Value			64.56%	
Individual Overall Deductible			$6,350	
Other individual deductibles for specific services				
Medical			$6,350	
Prescription Drugs			Integrated with Medical	
Dental			$0	
Individual Out-of-Pocket Maximum			$6,900	
Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health Care Provider's Office or Clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		20%	X
	Specialist visit		20%	X
	Preventive care/screening/immunization		$0	
Tests	Laboratory tests		20%	X
	X-rays and diagnostic imaging		20%	X
	Imaging (CT/PET scans, MRIs)		20%	X
Drugs to treat Illness or Condition*	Generic		20%	X
	Preferred brand		20%	X
	Non-preferred Brand		20%	X
	Specialty		20%	X
Outpatient Surgery	Facility fee (e.g. hospital room)		20%	X
	Physician/Surgeon fee		20%	X
Outpatient Non-surgical Clinic Visit**	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic		20%	X
Need Immediate Attention	Emergency room services		20%	X
	Emergency medical transportation		20%	X
	Urgent Care		20%	X
Hospital Stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental/Behavioral Health *****	M/B office visits		20%	X
	M/B outpatient services		20%	X
	M/B inpatient services		20%	X
Health, Substance Abuse needs	Substance abuse disorder office visits		20%	X
	Substance abuse disorder outpatient services		20%	X
	Substance abuse disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception services		$0	X
	Delivery and all inpatient services	Hospital	20%	X
		Professional		X

*Diabetes supplies, as defined by the carrier, and preferred brand insulin are provided with no cost-sharing.
**Coinsurance may not apply in a staff model HMO setting.

Help recovering or other special health needs	Home health care (up to 90 visits for 4 hours per calendar yr)	2%	X
	Outpatient rehabilitation services	20%	X
	Outpatient habilitation services	20%	X
	Skilled nursing care	20%	X
	Durable medical equipment	20%	X
	Hospice services	20%	X
Child eye care	Eye exam (OD)	$50	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0	
	Preventive – cleaning	$0	
	Preventive- x-ray	$0	
	Sealants per tooth	$0	
	Topical fluoride application	$0	
Child Dental Basic Services	Amalgam Fill – 1 surface	$41	
Child Dental Major Services	Root canal – molar	$512	
	Gingivectomy per Quad	$279	
	Extraction – single tooth exposed root or	$69	
	Extraction – complete bony	$241	
	Porcelain with Metal Crown	$523	
Child Orthodontics	Medically necessary orthodontics	$3,422	