Standard Plans Advisory Working Group
Platinum Plan 2018

Attachment to
1-9-2017 Report

Deleted: 2017

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Actuarial Value		88.20%	
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 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	
	Delivery and all inpatient services: Professional		

*Copay may not apply in a staff model HMO setting.

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Help recovering or other special health needs	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	

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D.C. Health Benefit Exchange
Standard Plans Advisory Working Group
Gold Plan 2018

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Actuarial Value		81.91%	
Individual Overall Deductible		$0	
Other individual deductibles for specific services			
Medical		$500	
Prescription Drugs		$0	
Dental		$0	
Individual Out-of-Pocket Maximum		$3,500	
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)	$600	
	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)	$250	
	Emergency medical transportation	$250	
	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 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
	Delivery and all inpatient services: Professional		X

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*Copay may not apply in staff model HMO setting.

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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	

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Standard Plans Advisory Working Group
Silver Plan 2018

Deleted: 2017

Actuarial Value		71.95%	
Individual Overall Deductible		N/A	
Other individual deductibles for specific services			
Medical		$3,500	
Prescription Drugs		$250	
Dental		$0	
Individual Out-of-Pocket Maximum		$6,250	
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	$50	
	X-rays and diagnostic imaging	$70	
	Imaging (CT/PET scans, MRIs)	$250	
Drugs to treat Illness or Condition	Generic	$15	
	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)	$250	X
	Emergency medical transportation	$250	X
	Urgent Care	$90	
Hospital Stay	Facility fee (e.g. hospital room)	20%	X
	Physician/surgeon fee		X
Mental/Behavioral Health	M/B office visits	$40	
	M/B outpatient services	5%	
	M/B inpatient services	20%	X
Health, Substance Abuse needs	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
	Delivery and all inpatient services: Professional		X

Deleted: 72
Deleted: 2,000
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*Coinsurance may not apply in staff model HMO setting.

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Help recovering or other special health needs	Home health care	$50	
	Outpatient rehabilitation services	$50	
	Outpatient habilitation services	$50	
	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	

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Standard Plans Advisory Working Group
Bronze Plan 2018

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Actuarial Value		64.81%	Deleted: 61.96
Individual Overall Deductible		$6,000	Deleted: 5,300
Other individual deductibles for specific services			
Medical		$5,000	
Prescription Drugs		$600	Deleted: 300
Dental		$0	
Individual Out-of-Pocket Maximum		$7,350	Deleted: 7,150
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	$50	
	Specialist visit	$75	Deleted: 50
	Preventive care/screening/immunization	$0	
Tests	Laboratory tests	$55	X Deleted: 50
	X-rays and diagnostic imaging	$75	X Deleted: 50
	Imaging (CT/PET scans, MRIs)	$500	X
Drugs to treat Illness or Condition	Generic	$25	
	Preferred brand	$75	X Deleted: 50%
	Non-preferred Brand	$100	X Deleted: 50%
	Specialty	$250	X Deleted: 50%
Outpatient Surgery	Facility fee (e.g. hospital room)	25%	X Deleted: 20
	Physician/Surgeon fee	25%	X Deleted: 20
Outpatient Non-surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	25%	X Deleted: 20
Need Immediate Attention	Emergency room services	25%	X Deleted: 20
	Emergency medical transportation	25%	X Deleted: 0
	Urgent Care	$100	Deleted: 50
Hospital Stay	Facility fee (e.g. hospital room)	25%	X Deleted: 20
	Physician/surgeon fee	25%	X Deleted: 20
Mental/Behavioral Health	M/B office visits	$50	
	M/B outpatient services	10%	
	M/B inpatient services	25%	X Deleted: 20
Health, Substance Abuse needs	Substance abuse disorder outpatient services	$50	
	Substance abuse disorder inpatient services	25%	X Deleted: 20
Pregnancy	Prenatal care and preconception services	$0	
	Delivery and all inpatient services — Hospital	25%	X Deleted: 20
	Delivery and all inpatient services — Professional		X

*Coinsurance may not apply in a staff model HMO setting.

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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	25%	X
	Durable medical equipment	25%	X
	Hospice services	25%	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	

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Standard Plans Advisory Working Group
HSA Bronze Plan 2018

Actuarial Value		60.95%	
Individual Overall Deductible		$6,200	
Other individual deductibles for specific services			
Medical		$6,200	
Prescription Drugs		Integrated with Medical	
Dental		$0	
Individual Out-of-Pocket Maximum		$6,550	
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	0	
	Urgent Care	$50	
Hospital Stay	Facility fee (e.g. hospital room)	20%	X
	Physician/surgeon fee	20%	X
Mental/Behavioral Health	M/B office visits	$50	
	M/B outpatient services	10%	
	M/B inpatient services	20%	X
Health, Substance Abuse needs	Substance abuse disorder outpatient services	$50	
	Substance abuse disorder inpatient services	20%	X
Pregnancy	Prenatal care and preconception services	$0	
	Delivery and all inpatient services – Hospital	20%	X
	Delivery and all inpatient services – Professional		X

*Coinsurance may not apply in a staff model HMO setting.

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Help recovering or other special health needs	Home health care (up to 90 visits for 4 hours per calendar yr)	20%	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	

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