

**Standard Plans Advisory Working Group
Platinum Plan 2019**

Actuarial Value		88.92%	
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 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 Professional	\$250 per day up to 5 days

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

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	

**D.C. Health Benefit Exchange
Standard Plans Advisory Working Group
Gold Plan 2019**

Actuarial Value		81.94%	
Individual Overall Deductible		\$0	
Other individual deductibles for specific services			
Medical		\$500	
Prescription Drugs		\$0	
Dental		\$0	
Individual Out-of-Pocket Maximum		\$4,000	
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	\$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)	\$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 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
		Professional	

*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	

**Standard Plans Advisory Working Group
Silver Plan 2019**

Actuarial Value		71.90%	
Individual Overall Deductible		N/A	
Other individual deductibles for specific services			
Medical		\$3,500	
Prescription Drugs		\$250	
Dental		\$0	
Individual Out-of-Pocket Maximum		\$7,600	
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)	\$350	X
	Emergency medical transportation	\$350	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%
		Professional	

*Coinsurance may not apply in staff model HMO setting.

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	

**Standard Plans Advisory Working Group
Bronze Plan 2018**

Actuarial Value		64.89%	
Individual Overall Deductible		\$7,250	
Other individual deductibles for specific services			
Medical		\$6,650	
Prescription Drugs		\$600	
Dental		\$0	
Individual Out-of-Pocket Maximum		\$7,900	
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	\$50	
	Specialist visit	\$80	
	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)	25%	X
	Physician/Surgeon fee	25%	X
Outpatient Non-surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	25%	X
Need Immediate Attention	Emergency room services	25%	X
	Emergency medical transportation	25%	X
	Urgent Care	\$100	
Hospital Stay	Facility fee (e.g. hospital room)	25%	X
	Physician/surgeon fee	25%	X
Mental/Behavioral Health	M/B office visits	\$50	
	M/B outpatient services	10%	
	M/B inpatient services	25%	X
Health, Substance Abuse needs	Substance abuse disorder outpatient services	\$50	
	Substance abuse disorder inpatient services	25%	X
Pregnancy	Prenatal care and preconception services	\$0	
	Delivery and all inpatient services	Hospital	
		Professional	25%
			X

*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	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	

**Standard Plans Advisory Working Group
HSA Bronze Plan 2018**

Actuarial Value		61.82%	
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	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 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	X
		Professional	X

*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)	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	