

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

<b>Actuarial Value</b>		88.20%	
<b>Individual Overall Deductible</b>		\$0	
<b>Other individual deductibles for specific services</b>			
<b>Medical</b>		\$0	
<b>Prescription Drugs</b>		\$0	
<b>Dental</b>		\$0	
<b>Individual Out-of-Pocket Maximum</b>		\$2,000	
<b>Common Medical Event</b>	<b>Service Type</b>	<b>Member Cost Share</b>	<b>Deductible Applies</b>
<b>Health Care Provider's Office or Clinic visit</b>	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$20	
	Specialist visit	\$40	
	Preventive care/screening/immunization	\$0	
<b>Tests</b>	Laboratory tests	\$20	
	X-rays and diagnostic imaging	\$40	
	Imaging (CT/PET scans, MRIs)	\$150	
<b>Drugs to treat Illness or Condition</b>	Generic	\$5	
	Preferred brand	\$15	
	Non-preferred Brand	\$25	
	Specialty	\$100	
<b>Outpatient Surgery</b>	Facility fee (e.g. hospital room)	\$250	
	Physician/Surgeon fee		
<b>Outpatient Non-surgical Clinic Visit*</b>	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	\$75	
<b>Need Immediate Attention</b>	Emergency room services (waived if admitted)	\$150	
	Emergency medical transportation	\$150	
	Urgent Care	\$40	
<b>Hospital Stay</b>	Facility fee (e.g. hospital room)	\$250 per day up to 5 days	
	Physician/surgeon fee		
<b>Mental/Behavioral Health</b>	M/B office visits	\$20	
	M/B outpatient services	\$20	
	M/B inpatient services	\$250 per day up to 5 days	
<b>Health, Substance Abuse needs</b>	Substance abuse disorder outpatient services	\$20	
	Substance abuse disorder inpatient services	\$250 per day up to 5 days	
<b>Pregnancy</b>	Prenatal care and preconception services		\$0
	Delivery and all inpatient services	Hospital	\$250 per day up to 5 days
Professional			

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

<b>Help recovering or other special health needs</b>	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	
<b>Child eye care</b>	Eye exam	\$0	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	\$0	
<b>Child Dental Diagnostic and Preventive</b>	Oral Exam	\$0	
	Preventive - cleaning	\$0	
	Preventive- x-ray	\$0	
	Sealants per tooth	\$0	
	Topical fluoride application	\$0	
	Space Maintainers - Fixed	\$0	
<b>Child Dental Basic Services</b>	Amalgam Fill – 1 surface	\$25	
<b>Child Dental Major Services</b>	Root canal - molar	\$300	
	Gingivectomy per Quad	\$150	
	Extraction – single tooth exposed root or	\$65	
	Extraction – complete bony	\$160	
	Porcelain with Metal Crown	\$300	
<b>Child Orthodontics</b>	Medically necessary orthodontics	\$1,000	

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

<b>Actuarial Value</b>		81.91%	
<b>Individual Overall Deductible</b>		\$0	
<b>Other individual deductibles for specific services</b>			
<b>Medical</b>		\$500	
<b>Prescription Drugs</b>		\$0	
<b>Dental</b>		\$0	
<b>Individual Out-of-Pocket Maximum</b>		\$3,500	
<b>Common Medical Event</b>	<b>Service Type</b>	<b>Member Cost Share</b>	<b>Deductible Applies</b>
<b>Health Care Provider's Office or Clinic visit</b>	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$25	
	Specialist visit	\$50	
	Preventive care/screening/immunization	\$0	
<b>Tests</b>	Laboratory tests	\$30	
	X-rays and diagnostic imaging	\$50	
	Imaging (CT/PET scans, MRIs)	\$250	
<b>Drugs to treat Illness or Condition</b>	Generic	\$15	
	Preferred brand	\$50	
	Non-preferred Brand	\$70	
	Specialty	\$150	
<b>Outpatient Surgery</b>	Facility fee (e.g. hospital room)	\$600	
	Physician/Surgeon fee		
<b>Outpatient Non-Surgical Clinic Visit*</b>	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	\$75	
<b>Need Immediate Attention</b>	Emergency room services (waived if admitted)	\$250	
	Emergency medical transportation	\$250	
	Urgent Care	\$60	
<b>Hospital Stay</b>	Facility fee (e.g. hospital room)	\$600 per day up to 5 days	X
	Physician/surgeon fee		X
<b>Mental/Behavioral Health</b>	M/B office visits	\$25	
	M/B outpatient services	\$25	
	M/B inpatient services	\$600 per day up to 5 days	X
<b>Substance Abuse needs</b>	Substance abuse disorder outpatient services	\$25	
	Substance abuse disorder inpatient services	\$600 per day up to 5 days	X
<b>Pregnancy</b>	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.

<b>Help recovering or other special health needs</b>	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	
<b>Child eye care</b>	Eye exam	\$0	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	\$0	
<b>Child Dental Diagnostic and Preventive</b>	Oral Exam	\$0	
	Preventive - cleaning	\$0	
	Preventive- x-ray	\$0	
	Sealants per tooth	\$0	
	Topical fluoride application	\$0	
	Space Maintainers - Fixed	\$0	
<b>Child Dental Basic Services</b>	Amalgam Fill – 1 surface	\$25	
<b>Child Dental Major Services</b>	Root canal - molar	\$300	
	Gingivectomy per Quad	\$150	
	Extraction – single tooth exposed root or	\$65	
	Extraction – complete bony	\$160	
	Porcelain with Metal Crown	\$300	
<b>Child Orthodontics</b>	Medically necessary orthodontics	\$1,000	

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

<b>Actuarial Value</b>		71.95%	
<b>Individual Overall Deductible</b>		N/A	
<b>Other individual deductibles for specific services</b>			
<b>Medical</b>		\$3,500	
<b>Prescription Drugs</b>		\$250	
<b>Dental</b>		\$0	
<b>Individual Out-of-Pocket Maximum</b>		\$6,250	
<b>Common Medical Event</b>	<b>Service Type</b>	<b>Member Cost Share</b>	<b>Deductible Applies</b>
<b>Health Care Provider's Office or Clinic visit</b>	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$40	
	Specialist visit	\$80	
	Preventive care/screening/immunization	\$0	
<b>Tests</b>	Laboratory tests	\$50	
	X-rays and diagnostic imaging	\$70	
	Imaging (CT/PET scans, MRIs)	\$250	
<b>Drugs to treat Illness or Condition</b>	Generic	\$15	
	Preferred brand	\$50	X
	Non-preferred Brand	\$70	X
	Specialty	\$150	X
<b>Outpatient Surgery</b>	Facility fee (e.g. hospital room)	20%	X
	Physician/Surgeon fee	20%	X
<b>Outpatient Non-surgical Clinic Visit*</b>	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	20%	X
<b>Need Immediate Attention</b>	Emergency room services (waived if admitted)	\$250	X
	Emergency medical transportation	\$250	X
	Urgent Care	\$90	
<b>Hospital Stay</b>	Facility fee (e.g. hospital room)	20%	X
	Physician/surgeon fee		X
<b>Mental/Behavioral Health</b>	M/B office visits	\$40	
	M/B outpatient services	5%	
	M/B inpatient services	20%	X
<b>Health, Substance Abuse needs</b>	Substance abuse disorder outpatient services	\$40	
	Substance abuse disorder inpatient services	20%	X
<b>Pregnancy</b>	Prenatal care and preconception services		\$0
	Delivery and all inpatient services	Hospital	20%
		Professional	

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

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

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

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

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

<b>Help recovering or other special health needs</b>	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
<b>Child eye care</b>	Eye exam (OD)	\$50	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	\$0	
<b>Child Dental Diagnostic and Preventive</b>	Oral Exam	\$0	
	Preventive - cleaning	\$0	
	Preventive- x-ray	\$0	
	Sealants per tooth	\$0	
	Topical fluoride application	\$0	
<b>Child Dental Basic Services</b>	Amalgam Fill – 1 surface	\$41	
<b>Child Dental Major Services</b>	Root canal - molar	\$512	
	Gingivectomy per Quad	\$279	
	Extraction – single tooth exposed root or	\$69	
	Extraction – complete bony	\$241	
	Porcelain with Metal Crown	\$523	
<b>Child Orthodontics</b>	Medically necessary orthodontics	\$3,422	

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

<b>Actuarial Value</b>		60.95%	
<b>Individual Overall Deductible</b>		\$6,200	
<b>Other individual deductibles for specific services</b>			
<b>Medical</b>		\$6,200	
<b>Prescription Drugs</b>		Integrated with Medical	
<b>Dental</b>		\$0	
<b>Individual Out-of-Pocket Maximum</b>		\$6,550	
<b>Common Medical Event</b>	<b>Service Type</b>	<b>Member Cost Share</b>	<b>Deductible Applies</b>
<b>Health Care Provider's Office or Clinic visit</b>	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	
<b>Tests</b>	Laboratory tests	20%	X
	X-rays and diagnostic imaging	20%	X
	Imaging (CT/PET scans, MRIs)	20%	X
<b>Drugs to treat Illness or Condition</b>	Generic	20%	X
	Preferred brand	20%	X
	Non-preferred Brand	20%	X
	Specialty	20%	X
<b>Outpatient Surgery</b>	Facility fee (e.g. hospital room)	20%	X
	Physician/Surgeon fee	20%	X
<b>Outpatient Non-surgical Clinic Visit*</b>	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital/hospital clinic	20%	X
<b>Need Immediate Attention</b>	Emergency room services	20%	X
	Emergency medical transportation	0	X
	Urgent Care	\$50	X
<b>Hospital Stay</b>	Facility fee (e.g. hospital room)	20%	X
	Physician/surgeon fee	20%	X
<b>Mental/Behavioral Health</b>	M/B office visits	20%	X
	M/B outpatient services	10%	X
	M/B inpatient services	20%	X
<b>Health, Substance Abuse needs</b>	Substance abuse disorder outpatient services	20%	X
	Substance abuse disorder inpatient services	20%	X
<b>Pregnancy</b>	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.

<b>Help recovering or other special health needs</b>	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
<b>Child eye care</b>	Eye exam (OD)	\$50	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	\$0	
<b>Child Dental Diagnostic and Preventive</b>	Oral Exam	\$0	
	Preventive - cleaning	\$0	
	Preventive- x-ray	\$0	
	Sealants per tooth	\$0	
	Topical fluoride application	\$0	
<b>Child Dental Basic Services</b>	Amalgam Fill – 1 surface	\$41	
<b>Child Dental Major Services</b>	Root canal - molar	\$512	
	Gingivectomy per Quad	\$279	
	Extraction – single tooth exposed root or	\$69	
	Extraction – complete bony	\$241	
	Porcelain with Metal Crown	\$523	
<b>Child Orthodontics</b>	Medically necessary orthodontics	\$3,422	