

WAHBE Required 2027 Standard Plan Designs

Individual Market Gold, Silver, and Bronze Plans

Benefits	2027 Standard Complete Gold	2027 Standard Vital Gold	2027 Standard Silver	2027 Standard Bronze
Deductible and Out-of-Pocket Maximum				
Medical/Pharmacy Integrated Deductible	Yes	Yes	Yes	Yes
Medical (or Integrated, if Applicable)/Pharmacy Deductibles (\$)	\$1,700	\$2,200	\$2,800	\$7,000
Medical/Pharmacy Integrated MOOP	Yes	Yes	Yes	Yes
Medical/Pharmacy Integrated MOOP (\$)	\$7,000	\$11,000	\$11,200	\$11,800
Office Visits				
Preventive Care/Screening/Immunization	\$0	\$0	\$0	\$0
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	\$15	\$15	\$20***	\$45***
Specialist Visit	\$40	\$40	\$65	\$100
Mental/Behavioral Health and Substance Use Disorder Outpatient Services-Office	\$15	\$15	\$20***	\$45***
Emergency/Urgent Care Services				
Emergency Care Services	\$450	\$800	\$800	40%
Urgent Care	\$35	\$35	\$65	\$100
Ambulance	\$375	\$375	\$375	40%
Outpatient Services				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$350	\$350	\$600	40%
Outpatient Surgery Physician/Surgical Services	\$75	\$75	\$200	40%
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other	\$15	\$15	\$20	40%
Outpatient Diagnostic Tests				
Laboratory Outpatient and Professional Services	\$30	\$30	\$40	40%
X-rays and Diagnostic Imaging	\$30	\$30	\$65	40%
Advanced Imaging (CT/PET Scans, MRIs)	\$300	\$300	30%	40%
Inpatient Services				
All Inpatient Hospital Services (inc. MH/SUD, Maternity)	\$525*	\$650*	\$800*	40%
Skilled Nursing Facility	\$350**	\$350**	\$800**	40%
Pharmacy				
Generics	\$10	\$10	\$25	\$32
Preferred Brand Drugs	\$60	\$75	\$75	40%
Non-Preferred Brand Drugs	\$100	20%	\$250	40%
Specialty Drugs (i.e. high-cost)	\$100	20%	\$250	40%
All Other Benefits				
Speech Therapy	\$25	\$30	\$40	40%
Occupational and Physical Therapy	\$25	\$30	\$40	40%
Durable Medical Equipment (DME)	20%	20%	30%	40%
Home Health	\$15**	\$15**	\$30**	\$50**
Hospice	\$15**	\$15**	\$30**	\$50**
All Other Benefits	20%	20%	30%	40%
2027 AV	81.89%	78.22%	71.92%	63.99%

Shaded Items are not Subject to Deductible.

* Per day copay, maximum of five copays per stay;

** Per day copay;

*** Eligible for two visits at \$1 copay, after which stated cost-sharing applies.

Note: For all standard plans, the 2027 AV is based on a modified version of the federal 2027 AV Calculator that accounts for unique plan features.

Individual Market Silver Plan: CSR Variations

Benefits	2027 Standard Silver 94% AV	2027 Standard Silver 87% AV	2027 Standard Silver 73% AV
Deductible and Out-of-Pocket Maximum			
Medical/Pharmacy Integrated Deductible	Yes	Yes	Yes
Medical (or Integrated, if Applicable)/Pharmacy Deductibles (\$)	\$0	\$550	\$2,600
Medical/Pharmacy Integrated MOOP	Yes	Yes	Yes
Medical/Pharmacy Integrated MOOP (\$)	\$4,000	\$4,000	\$9,600
Office Visits			
Preventive Care/Screening/Immunization	\$0	\$0	\$0
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	\$1	\$5***	\$20***
Specialist Visit	\$15	\$20	\$65
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Office	\$1	\$5***	\$20***
Emergency/Urgent Care Services			
Emergency Care Services	\$225	\$425	\$800
Urgent Care	\$15	\$30	\$65
Ambulance	\$75	\$175	\$375
Outpatient Services			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$100	\$325	\$600
Outpatient Surgery Physician/Surgical Services	\$65	\$120	\$200
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other	\$1	\$5	\$20
Outpatient Diagnostic Tests			
Laboratory Outpatient and Professional Services	\$15	\$20	\$40
X-rays and Diagnostic Imaging	\$20	\$30	\$65
Advanced Imaging (CT/PET Scans, MRIs)	15%	20%	30%
Inpatient Services			
All Inpatient Hospital Services (inc. MH/SUD, Maternity)	\$100*	\$425*	\$800*
Skilled Nursing Facility	\$100**	\$425**	\$800**
Pharmacy			
Generics	\$5	\$10	\$20
Preferred Brand Drugs	\$15	\$35	\$75
Non-Preferred Brand Drugs	\$35	\$160	\$250
Specialty Drugs (i.e. high-cost)	\$35	\$160	\$250
All Other Benefits			
Speech Therapy	\$15	\$20	\$40
Occupational and Physical Therapy	\$15	\$20	\$40
Durable Medical Equipment (DME)	15%	20%	30%
Home Health	\$5**	\$10**	\$30**
Hospice	\$5**	\$10**	\$30**
All Other Benefits	15%	20%	30%
2027 AV	94.78%	87.96%	73.95%

Shaded Items are not Subject to Deductible.

* Per day copay, maximum of five copays per stay;

** Per day copay;

*** Eligible for two visits at \$1 copay, after which stated cost-sharing applies.

Note: For all standard plans, the 2027 AV is based on a modified version of the federal 2027 AV Calculator that accounts for unique plan features.

2027 Standard Plans Designs Appendix A

This Appendix applies to standard plan designs at all metal levels unless otherwise designated. These requirements apply only for covered services under the plan.

1. The standard plan designs outline the cost-sharing for the consumer for a given benefit category.
2. The standard plan designs do not address cost-sharing amounts for any out-of-network services except for those services required under state or federal law to have the in-network cost-share amount. For example, out of network emergency care services would have an in-network cost-sharing under the Balance Billing Protection Act.
3. For all services with a co-pay that are not subject to the deductible, the co-pay amount does not accumulate toward the deductible, but the full co-pay amount paid for the service will accumulate toward the maximum out-of-pocket amount.
4. For services with a co-pay that are subject to the deductible, the full amount of first-dollar out-of-pocket spending accrues toward the deductible.
5. Per the essential health benefit base-benchmark plan, the following services must be covered for, at minimum, the identified number of visits:
 - a. Chiropractic: 10 visits
 - b. Home health care services: 130 days
 - c. Hospice respite services: 14 days per lifetime
 - d. Outpatient rehabilitation, combined physical, occupational, and speech therapy, services: 25 visits
 - e. Outpatient habilitation services: 25 visits
 - f. Inpatient rehabilitative services: 30 days
 - g. Inpatient habilitative services: 30 days
 - h. Skilled nursing facility services: 60 days
6. Co-payments charged to a consumer may never exceed the actual cost for the service. For instance, if a co-pay is \$45 and the service is \$30, the cost-share responsibility of the consumer would be \$30.
7. For prescription drugs in any tier, the cost-share defined is for a 30-day supply. Carriers may determine to allow for mail order prescriptions at a reduced per-unit cost (e.g., a 90-day supply).
8. Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the plan's in-network maximum out-of-pocket.
9. Office visits for the treatment of mental health, behavioral health, or substance use disorder conditions shall be categorized as Mental/Behavioral Health and Substance Use Disorder Outpatient - Office Visits, regardless of provider type.

Other Practitioner Office Visits (e.g., Nurse, Physician Assistant, Chiropractor, Acupuncture) shall generally be treated as a Primary Care Visit to Treat an Injury or Illness or Preventive Care/Screening Immunization. A carrier may include in the Other Practitioner category: nurse practitioners, certified nurse midwives, respiratory therapists, clinical psychologists, licensed clinical social worker, marriage and family therapists, and applied behavior analysis therapists. A carrier is not precluded from using another comparable benefit category for a service provided by one of these practitioners.

Services provided by other practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral Health and Substance Use Disorder Outpatient Services – Office Visits or Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other. The copay for Mental/Behavioral Health and Substance Use Disorder Outpatient Office visits may be applied to Mental/Behavioral Health and Substance Use Disorder Outpatient services provided in an urgent care setting.

10. Services with a co-pay should be charged with the following methodology: one co-pay per benefit category per day per provider. For example, a charge for a lab draw and read at a primary care visit by the same provider would result in one lab co-pay and one primary care office visit co-pay for the individual.
11. For outpatient services where a facility fee and physician/surgical services are not billed separately, an issuer may apply the cost-sharing requirements for both the facility fee and the physician/surgical services to the total charge.
12. For outpatient encounters that include multiple services, an issuer may apply the cost-sharing requirements for each service provided. For instance, an outpatient encounter involving a surgeon, radiologist, and anesthesiologist would result in three cost-share payments for the consumer.
13. For instances where there is a co-pay for Skilled Nursing Facility and All Inpatient Hospital Services, it is a per-day co-pay (with a limit of five co-pays for an inpatient stay). For instance, a two-day stay would result in two co-pays for the consumer.
14. The co-pay for All Inpatient Hospital Services is a bundled fee that covers the facility fee and professional services. For instance, an individual with a one-day stay at a hospital in the Complete Gold standard plan would pay the \$525 co-pay for Inpatient Hospital Services and no charge for the Inpatient Physician and Surgical Services. Similarly, an individual in the Vital Gold standard plan would pay the \$650 co-pay before reaching the deductible. For the Silver and Bronze standard plans, any charges would first accrue to the deductible, and after the deductible is met, the individual would pay the applicable co-pay or co-insurance.
15. The cost share amount for Emergency Care Services covers facility fee and professional services.
16. Unless otherwise noted in this appendix, carriers are permitted to assign any service to any benefit category if permissible under state and federal law.
17. 2026 WA Essential Health Benefits (EHBs) additions remain in effect for 2027 and are as follows:
 - a. Initial assessments and annual hearing exams for Hearing Aids shall be categorized as Primary Care Visits. These visits are shared with the PCP/Other Practitioner category, for a total of two \$1 visits in Silver and Bronze plans.
 - b. Hearing Aids are not subject to the deductible and are the same co-insurance amount as the DME category.
 - c. Artificial Insemination shall be categorized as All Other Benefits.
 - d. Human Donor Milk will be subject to zero cost sharing (no deductible, copay, or coinsurance will apply).
18. While these 2027 standard plan designs do not specify any requirements for virtual care, HBE is exploring this option for future years and is planning to collect existing data from carriers to support this work.
19. Issuers are required to file and use a contracted network with standard plans.

**2027 Standards Plans Designs Appendix B
Plan and Benefit Template Standardization**

These are select categories from the CMS Plan and Benefits Template that the Exchange is standardizing for 2027. Carriers shall file standard plan benefits in the (PBT) with the OIC in accordance with the chart below. The Exchange may standardize more categories in the PBT in future years. The Exchange understands different cost shares may apply depending on the specific service, but the intent is for alignment across carriers at the PBT level. Carriers may opt to file lower cost sharing on a benefit with an approved exception from the Exchange. Note: Blue shaded items are not subject to the deductible.

Benefit	Complete Gold Cost Share	Vital Gold Cost Share	Silver Cost Sharing	Bronze Cost Share
Primary Care Visit to Treat an Injury or Illness ¹	\$15	\$15	\$20	\$45
Specialist Visit	\$40	\$40	\$65	\$100
Other Practitioner Office Visit (Nurse, Physician Assistant) ¹	\$15	\$15	\$20	\$45
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$350 copay after deductible	\$350 copay after deductible	\$600 copay after deductible ²	40% coinsurance after deductible
Outpatient Surgery Physician/Surgical Services	\$75 copay after deductible	\$75 copay after deductible	\$200 copay after deductible ²	40% coinsurance after deductible
Hospice	\$15 copay per day	\$15 copay per day	\$30 copay per day	\$50 copay per day
Urgent Care Centers or Facilities	\$35	\$35	\$65	\$100
Home Health Care Services	\$15 copay per day	\$15 copay per day	\$30 copay per day	\$50 copay per day
Emergency Room Services	\$450 copay after deductible	\$800 copay after deductible	\$800 copay after deductible ²	40% coinsurance after deductible
Emergency Transportation/Ambulance	\$375 copay	\$375 copay	\$375 copay	40% coinsurance after deductible
Inpatient Hospital Services (e.g., Hospital Stay) ³	\$525 copay per day	\$650 copay per day after deductible	\$800 copay per day after deductible ²	40% coinsurance after deductible
Inpatient Physician and Surgical Services	No charge	No charge after deductible	No charge after deductible ²	40% coinsurance after deductible

Benefit	Complete Gold Cost Share	Vital Gold Cost Share	Silver Cost Sharing	Bronze Cost Share
Skilled Nursing Facility	\$350 copay per day after deductible	\$350 copay per day after deductible	\$800 copay per day after deductible ²	40% coinsurance after deductible
Prenatal and Post Natal Care	No charge	No charge	No charge	No charge
Delivery and All Inpatient Services for Maternity Care ³	\$525 copay per day	\$650 copay per day after deductible	\$800 copay after deductible ²	40% coinsurance after deductible
Mental/Behavioral Health Office Visit	\$15 copay	\$15 copay	\$20 copay	\$45 copay
Mental/Behavioral Health Inpatient Services ³	\$525 copay per day	\$650 copay per day after deductible	\$800 copay per day after deductible ²	40% coinsurance after deductible
Substance Abuse Disorder Office Visit ¹	\$15 copay	\$15 copay	\$20 copay	\$45 copay
Substance Abuse Disorder Inpatient Services ³	\$525 copay per day	\$650 copay per day after deductible	\$800 copay per day after deductible ²	40% coinsurance after deductible
Generic Drugs	\$10	\$10	\$25	\$32
Preferred Brand Drugs	\$60	\$75	\$75	40% coinsurance after deductible
Non-Preferred Brand Drugs	\$100	20% coinsurance after deductible	\$250 copay after deductible ²	40% coinsurance after deductible
Specialty Drugs	\$100	20% coinsurance after deductible	\$250 copay after deductible ²	40% coinsurance after deductible
Outpatient Rehabilitation Services	\$25	\$30	\$40	40% coinsurance after deductible
Habilitation Services	\$25	\$30	\$40	40% coinsurance after deductible
Chiropractic Care ¹	\$15	\$15	\$20	\$45
Durable Medical Equipment	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible ²	40% coinsurance after deductible

Benefit	Complete Gold Cost Share	Vital Gold Cost Share	Silver Cost Sharing	Bronze Cost Share
Hearing Aids	20% coinsurance	20% coinsurance	30% coinsurance	40% coinsurance
Imaging (CT/PET Scans, MRIs)	\$300 copay after deductible	\$300 copay after deductible	30% coinsurance after deductible ²	40% coinsurance after deductible
Preventive Care/Screening/Immunization	No charge	No charge	No charge	No charge
Acupuncture ¹	\$15	\$15	\$20	\$45
Routine Eye Exam for Children	No charge	No charge	No charge	No charge
Eye Glasses for Children	No charge	No charge	No charge	No charge
Rehabilitative Speech Therapy	\$25	\$30	\$40	40% coinsurance after deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$25	\$30	\$40	40% coinsurance after deductible
Well Baby Visits and Care	No charge	No charge	No charge	No charge
Laboratory Outpatient and Professional Services	\$30	\$30	\$40	40% coinsurance after deductible
X-Rays and Diagnostic Imaging	\$30	\$30	\$65	40% coinsurance after deductible
Abortion for Which Public Funding is Prohibited	No charge	No charge	No charge	No charge
Transplant ³	\$525 copay per day	\$650 copay per day after deductible	\$800 copay after deductible ²	40% coinsurance after deductible
Diabetes Education	No charge	No charge	No charge	No charge
Prosthetic Devices	20% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible ²	40% coinsurance after deductible
Nutritional Counseling	No charge	No charge	No charge	No charge
Diabetes Care Management	No charge	No charge	No charge	No charge

¹Customers can receive up to four \$1 visits in Silver and Bronze plans: two \$1 primary care visits and two \$1 mental health/substance use disorder office visits. Other Practitioner Office Visit (Nurse, Physician Assistant) are considered primary care visits. Acupuncture and chiropractic visits may be considered either primary care or mental health/substance use disorder visits, depending on the customer's diagnosis.

² Applicability of deductible varies by silver cost-sharing variant. See “WAHBE Required 2027 Standard Plan Design” chart.

³Carrier shall administer copay per day up to 5 days like Inpatient Hospitals for Complete Gold, Vital Gold and Silver plans.