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2021 Draft Standard Plans for Public Comment

Benefits	Standard Gold	Standard Silver	Standard Bronze	Standard Bronze (HSA)
Deductible ($)	$500	$2,000	$6,000	$6,250
MOOP ($)	$5,750	$7,900	$8,150	$6,900
Emergency Room Services	$400	$750	40%	40%
Urgent Care	$35	$60	$90	40%
All Inpatient Hospital Services (inc. MH/SUD,Maternity)	$500 *	$750 *	40%	40%
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	$15	$25	$30	40%
Specialist Visit	$35	$60	$90	40%
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	$15	$25	$30	40%
Advanced Imaging (CT/PET Scans, MRIs)	$300	30%	40%	40%
Speech Therapy	$20	$30	40%	40%
Occupational and Physical Therapy	$20	$30	40%	40%
Preventive Care/Screening/Immunization	$0	$0	$0	$0
Laboratory Outpatient and Professional Services	$15	$30	$30	40%
X-rays and Diagnostic Imaging	$25	$60	40%	40%
Skilled Nursing Facility	$300	$750	40%	40%
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$300	$500	40%	40%
Outpatient Surgery Physician/Surgical Services	$50	$100	40%	40%
Generics	$10	$20	$25	40%
Preferred Brand Drugs	$55	$65	$70	40%
Non-Preferred Brand Drugs	$90	$150	40%	40%
Specialty Drugs (i.e. high-cost)	$90	$150	40% **	40%
Ambulance	$375	$375	40%	40%
Routine Eye Exam for Children	$0	$0	$0	$0
All Other Benefits	20%	30%	40%	40%
Federal AV	81.31%	71.31%	64.31%	62.29%

***Limit of 5 copays per stay, ** Limit of $300 per prescription**
Shaded items are not subject to the deductible

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2021 Draft Standard Plans for Public Comment – CSR Variants

Section 1402 of the Affordable Care Act established reduced cost-sharing for certain individuals enrolling in qualified health plans. Carriers are required to provide for all silver plans, three cost-share variants meeting certain actuarial value requirements. In order to qualify for a cost-share variant an individual must meet the following income requirements: a) income up to 150% of the Federal Poverty Level will qualify for a standard silver with an actuarial value of 94%; b) income between 151 – 200% of the Federal Poverty level will qualify for a standard silver plan with an actuarial value of 87%; c) income between 200 – 250% of the Federal Poverty level will qualify for a standard silver with an actuarial value of 73%.

Benefits	Standard Silver	Standard Silver 73% AV	Standard Silver 87% AV	Standard Silver 94% AV
Deductible ($)	$2,000	$1,800	$850	$150
MOOP ($)	$7,900	$6,500	$1,900	$900
Emergency Room Services	$750	$700	$375	$150
Urgent Care	$60	$55	$30	$15
All Inpatient Hospital Services (inc. MH/SUD,Maternity) *	$750	$700	$375	$100
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	$25	$20	$10	$5
Specialist Visit	$60	$55	$30	$15
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	$25	$20	$10	$5
Advanced Imaging (CT/PET Scans, MRIs)	30%	30%	20%	15%
Speech Therapy	$30	$30	$15	$5
Occupational and Physical Therapy	$30	$30	$15	$5
Preventive Care/Screening/Immunization	$0	$0	$0	$0
Laboratory Outpatient and Professional Services	$30	$30	$15	$5
X-rays and Diagnostic Imaging	$60	$55	$30	$15
Skilled Nursing Facility	$750	$700	$375	$100
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$500	$475	$250	$100
Outpatient Surgery Physician/Surgical Services	$100	$90	$50	$25
Generics	$20	$17	$10	$3
Preferred Brand Drugs	$65	$65	$30	$15
Non-Preferred Brand Drugs	$150	$150	$100	$35
Specialty Drugs (i.e. high-cost)	$150	$150	$100	$35
Ambulance	$375	$325	$175	$75
Routine Eye Exam for Children	$0	$0	$0	$0
All Other Benefits	30%	30%	20%	15%
Federal AV	71.31%	73.93%	87.59%	94.50%

Shaded items are not subject to the deductible

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 do not address cost-sharing amounts for any out-of-network services with the exception of Emergency Room Services, which will have the in-network cost-share amount.
2. For all services with a co-pay prior 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.
3. For services with a co-pay and deductible, the full amount of first-dollar out-of-pocket spending accrues toward the deductible.
4. Per WAC 284-43-5602, designating the essential health benefit base-benchmark plan, the following annual visit limits apply:
    a. Chiropractic: 10 visits
    b. Acupuncture: 12 visits
    c. Home Health Care Services: 130 days
    d. Hospice services: 14 days per lifetime
    e. Outpatient rehabilitation services: 25 visits
    f. Habilitation services: 25 visits
    g. Rehabilitative occupational and physical therapy: 30 visits
    h. Rehabilitative speech therapy: 30 visits
5. Laboratory Outpatient and Professional Services with a co-pay are charged per encounter.
6. Co-payments 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 by 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 cost.
8. For purposes of administration of the standard bronze HSA plan, medical services and items are classified as preventive care with respect to an individual with the relevant chronic condition as permitted in IRS Notice 2019-45, "Additional Preventive Care Benefits Permitted to be Provided by a High-Deductible Health Plan Under §223."
9. 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.
10. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
11. Other Practitioner Office Visits (Nurse, Physician Assistant) shall generally be treated as a Primary Care Visit to Treat an Injury or Illness. 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, applied behavior analysis therapists, acupuncture practitioners, chiropractic practitioners, registered dieticians and other nutrition advisors. A carrier is not precluded from using another comparable benefit category other than the specialist visit 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 or Substance Use Disorder Outpatient Services.
12. If a facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.

13. Chemotherapy, radiation, infusion therapy, and dialysis shall be categorized as All Other Benefits. A carrier is not precluded from using another comparable benefit category for these services.
14. Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be different but not more than those listed in the standard plan design, if necessary, for compliance with MHPAEA.