**2022 Standard Plans Designs Appendix**

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 with the exception of those services required under state or federal law to have the in-network cost-share amount. For example, out of network emergency 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 WAC 284-43-5602, designating the essential health benefit base-benchmark plan, the following services must be covered for, at minimum, the identified number of visits:
	1. Chiropractic: 10 visits
	2. Acupuncture: 12 visits
	3. Home Health Care Services: 130 days
	4. Hospice respite services: 14 days per lifetime
	5. Outpatient rehabilitation, combined physical, occupational, and speech therapy, services: 25 visits
	6. Outpatient habilitation services: 25 visits
	7. Inpatient rehabilitative services: 30 days
	8. Inpatient habilitative services: 30 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 (Nurse, Physician Assistant) 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, 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 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.
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 covers the facility fee and professional services. For instance, an individual with a one-day stay at a hospital in the Gold standard plan would pay only the $525 co-pay.
15. The cost share amount for Emergency Room 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.