May 10, 2021

Christine Gibert
Policy Director
Washington Health Benefit Exchange
Via email: Christine.gibert@wahbexchange.org

RE: Actuarial Value Certification for WAHBE 2022 Standard Medical Plan Designs

Dear Christine:

This memo replaces earlier versions provided on April 19, 2021. Minor changes were made to the language in this report to reflect the finalized 2022 Actuarial Value Calculator (AVC) released May 6, 2021 and final 2022 NBPP. No change was made to the final 2022 AVC compared to the draft AVC 2022 calculator and any updates found within the 2022 NBPP had no impact on the 2022 plan designs as found in prior reports. Therefore, there are no changes to actuarial values (AVs) or plan designs from the April 19, 2021 version of this report.

The prior version of the report, provided on April 19th, had updated the AVC results for the Standard Gold, Standard Silver 87% CSR Variation, and Standard Silver 94% AV CSR variation to reflect a separate medical and $0 drug deductible as the deductible does not apply to any pharmacy services, per guidance from Washington State Office of the Insurance Commissioner (OIC). Earlier versions applied a combined medical/pharmacy deductible, consistent with the other plans. This change resulted in an increase in the unadjusted and final Actuarial Values denoted throughout this report. Note that this change did not impact the adjustment factor calculation. As described below, the adjustment factor is developed through a readjudication model, which takes individual claims and re-prices the member cost sharing and plan paid amounts for each claim based on the appropriate plan design. As the deductible is waived for pharmacy claims for the plans above, the pharmacy claims do not accumulate towards the deductible and the deductible for a member is considered to be met at the same point, regardless of whether the pharmacy deductible was combined with medical or separate. Therefore, the resulting AVs from the readjudication model used to determine the adjustment factor did not change.

These methodological changes were reflected in the memo provided on April 9, 2021. There are no changes to the methodology or results between the April 9, 2021 version and this current version of the memo. However, this memo further clarifies that for all benefits not explicitly mentioned, the readjudication model used to develop the adjusted AV was run in agreement with the AVC inputs.

The Affordable Care Act (ACA) requires that non-grandfathered health care coverage provided by issuers in the individual market cover all Essential Health Benefits (EHBs) and have AVs that fall under the Platinum (90% AV), Gold (80% AV), Silver (70% AV) or Bronze (60% AV) tiers. The ACA allows for a -4% to +2% de minimis range around these target AVs, the Bronze plan allows for a -4/+5% de minimis range[1]. For example, any plan design that has an AV from 66-72%, would be considered a Silver plan. The ACA also defines AVs for Cost-Sharing Reduction (CSR) Plan variations that are available to individuals meeting income and other eligibility criteria and enrolling in a Silver level plan in the individual market. These CSR variation AVs are 73%, 87% and 94%. The ACA allows for a 1% de minimis range around the target AVs for CSR plans.

The Center for Consumer Information and Insurance Oversight (CCIIO) provides an Actuarial Value Calculator (AVC)[2] that issuers must use to determine the AV of a plan. While CCIIO developed the AVC such to accommodate most plans, some plan designs have features which are not supported by the AVC. In these instances, an actuary can either modify the inputs to most closely represent the plan design, or an actuary can modify the results of the AVC to account for the features not supported by the AVC. An actuarial certification documenting the development of the AV for these plan designs is required.

Washington Health Benefit Exchange (WAHBE) defines standard plan designs that issuers participating on the Exchange must offer. Standard plan designs are defined for the individual market. For 2022, WAHBE is defining one standard plan design for the individual market for the Gold, Silver (and three corresponding CSR plan levels), and Bronze levels.

WAHBE contracted with Wakely Consulting Group, LLC (Wakely) to assist with the development of 2022 standard plan designs and validation of the federal AVs for the 2022 standard plan designs. Compliance of the benefit designs in relation to other regulatory benefit design constraints has not been evaluated by Wakely.

The final Notice of Benefit and Payment Parameters (NBPP)[3] for the 2022 plan year was released on April 30, 2021. The NBPP finalized a single annual limit, or MOOP of $8,700, which reflects a $400 reduction from the draft proposed limit. In addition, the final Federal AVC was released on May 6, 2021. No changes were made between the draft and final versions of the AVC. No changes were required to the plan designs due to the requirements finalized.

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[1] CMS finalized a rule April 18, 2017 that allows plans a wider AV range of -4% to +2% (or -4% to +5% for Bronze plans described above), compared to the current range of -2% to +2%. The regulation requires that the Bronze plan satisfy certain criteria to be eligible.

[2] http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html

[3] https://www.federalregister.gov/public-inspection/2021-09102/patient-protection-and-affordable-care-act-notice-of-benefit-and-payment-parameters-for-2022-and

A summary of WAHBE's standard plan designs is in Appendix C. Most of the cost sharing features of 2022 standard plan designs can be accommodated by the federal AVC. However, each of the plan designs have features not supported by the AVC and thus an actuarial certification is required. The OIC has confirmed with the CCIIO that the AVC accrues any copays applied during the deductible period toward the deductible. Plans that include services that are not subject to the deductible and also have a copay that does not count towards the deductible cannot be input into the current AVC without a unique benefit design certification or an actuarial attestation that the AV adjustment applicable to this plan feature is immaterial.

In addition, the Bronze standard plan design has been updated in 2022 to specify that outpatient Mental Health/Substance Use Disorder (MH/SUD) services provided in an office setting will incur a copay, similar to the 2021 plan designs, but other outpatient MH/SUD services (non-office visit) will be subject to the deductible and incur a coinsurance rate once the deductible has been met. As the AVC only allows a single benefit input for all outpatient MH/SUD services, this tiered design constitutes a unique benefit design. The adjustment made to the AVC for these categories is described below. The MH/SUD outpatient services for Silver and Gold level plans will continue to be subject to the same copay, regardless of location, therefore no modifications are required to the inputs of the AVC for those plans.

The standard plan appendix, found in Appendix C, was also updated from the 2021 plan appendix, to note that 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. The Federal AVC does not account for all service categories and urgent care services is one of those that is not explicitly included in the calculator. Therefore, this actuarial value certification is applicable without any additional adjustment for a carrier that chooses to apply the copay for Mental/Behavioral Health and Substance Use Disorder Outpatient Office Visits to Mental/Behavioral Health and Substance Use Disorder Outpatient services provided in an urgent care setting.

Methodology

Wakely is providing an actuarial certification for the adjusted actuarial values allowed under §156.135(b)(3) in Appendix A and B.

A summary of WAHBE's standard plan designs for 2022 is in Appendix C. Wakely utilized the 2022 federal AVC to determine the AV for all plans, entering plan designs to the extent that they fit the AVC. Screen shots of the AVC inputs and outputs for all calculations performed for plan designs that were accommodated by the AVC can be found in Appendix D.

We adjusted the resulting AV for the plan design features that deviate from the parameters of the AVC. The AVC does not accommodate copays that do not accrue to the deductible for benefits that are not subject to the deductible. The AVC calculates actuarial values with copays that accrue to the deductible.

Also, for the Bronze standard plan, separate cost sharing values will apply for MH/SUD services obtained in an office setting versus other outpatient services. The AVC allows for only a single benefit input for MH/SUD outpatient services. It was not necessary to provide any adjustment for outpatient MH/SUD services provided in an urgent care setting because the AVC does not calculate inputs for urgent care services.

Wakely developed a separate calculation of actuarial values based on readjudication of detailed claim data for nationwide individual ACA claims experience in 2017. Wakely's ACA claims experience consists of 4.3 million lives and $14.8 billion in allowed costs. The data reflects nationwide experience and roughly mirrors the ACA membership distribution by census region, though not all states or areas are represented.

For purpose of this readjudication, Wakely has used a randomized 10% sample of this dataset consisting of approximately 400,000 lives. This 10% sample population was determined to be fully credible. The determination of full credibility depends on the assumed variation in the claim experience and was based on an application of classical credibility theory. Full credibility was determined based on the number of individuals that are needed to have a probability of 95% of being within 10% of the expected claim amount (consistent with Medicare criteria). The credibility threshold was calculated using Wakely's ACA claims experience for years 2016 to 2017.

The readjudication process analyzes the specific claims for an individual and their family members and accumulates cost sharing for the individual to determine the ultimate total cost sharing paid by individuals and the portion of the claims paid by the issuers for a given plan design. The process is as follows:

1. Wakely developed a SAS model that sequentially runs the detailed claims data for an individual and a family through logic to calculate the respective cost sharing that an individual would owe and the portion of a claim that would be paid by the insurer. This includes accumulation of cost sharing that accrues to the deductible as well as cost sharing accruing to the overall maximum out of pocket limits for a plan.
2. Wakely set up the cost sharing in the model to reflect the cost sharing structure for the specific plan designs for each of the defined standard plans. These included the Standard Gold, Standard Silver, and Standard Bronze plan designs. We also set up the cost sharing to reflect the three CSR variations of the Standard Silver plan. The cost sharing applied is shown in the specific plan designs found in Appendix C below.
3. The model used for the adjudication was calibrated to reflect Washington average claims cost and also reflects trending the claims experience used from 2017 to 2021. The average claims cost used in the calibration were derived from the carrier's filed 2020 URRTs, trended to 2021. The adjustment was done based on high level category of service for inpatient, outpatient, professional, pharmacy, and other services. As the 2022 Federal AVC applied a 0% trend to medical and pharmacy claims from 2021 to 2022, this approach is consistent with the data

underlying the AVC model.

4. Two actuarial values were calculated using the readjudication model.

    a. First, actuarial values for each standard plan design were calculated assuming that the copays for services that are not subject to the deductible accrue to the deductible before the deductible is met. In order to do this, the detailed claims were run through the adjudication model in order to accumulate the total cost sharing paid by the individual and the total paid by the carrier. When accumulating the cost sharing for the individual, the copay was also applied to the accumulating deductible to reflect the methodology followed by the Federal AVC. This means that when the individual had a copay, the accumulating deductible would be the accumulating deductible plus the copay instead of just the accumulating deductible.

        All services identified as MH/SUD outpatient applied a single copay, as noted for the MH/SUD office visit services in Appendix C and consistent with how benefits were entered in the AVC as shown in the screenshots below in Appendix D.

        All other services were run in accordance with the AVC inputs as shown in Appendix D, including whether the medical and pharmacy deductibles are combined or separate.

        After running the adjudication, the actuarial value for those claims was calculated by taking the total paid by the carrier divided by the total allowed for all claims that were run through the model.

    b. The model was then revised to reflect the assumption that copays for services that are not subject to the deductible will not accrue to the deductible. In contrast to the method described above, the copays under this logic would not accrue to the accumulating deductible cost share for the individual. Thus, the copay and the accruing deductible would be kept separate, similar to the approach for the standard plans.

        For the standard Bronze plan, MH/SUD Outpatient Other (non-office visit) services were updated to reflect that these costs accrue towards the deductible and are subject to coinsurance. No change was made to the cost sharing for MH/SUD Outpatient-Office Visits as these services would continue to apply the copay as noted in 4a above.

        No change was made to the MH/SUD Outpatient cost sharing for the standard Gold or Silver plans as these plans would continue to apply the copay as noted in 4a above.

        These changes were made in the algorithm for adjudication in the SAS model. No other changes were made to the model and all other services were run in accordance with the AVC inputs as shown in Appendix D, including whether the medical and pharmacy deductibles are combined or separate. Actuarial values for each standard plan design were calculated using this revised assumption by dividing the total claims paid by the carrier by the total allowed claims.

5. We calculated the adjustment factor for each plan design by dividing the actuarial value calculated assuming that copays do not accrue to the deductible and with separate cost sharing applied for MH/SUD Outpatient-Office Visits and MH/SUD Outpatient-Other (described in 4b) by the actuarial value calculated assuming that copays do accrue to the deductible and a single copay for MH/SUD services regardless of place of service (described in 4a).

   Given that the only differences in the two AV's was from the method in 4a having the copay accrue to the deductible and a single MH/SUD Outpatient copay and 4b with the copay not accruing to the deductible and separate MH/SUD Outpatient cost sharing for Office Visits and Other services, the difference in AV's will give us the impact the differing copay and MH/SUD methodologies have on a plan's AV.

6. The factors were then applied to the AV determined by the AVC for each standard plan by multiplying the adjustment factor times the AV determined by the AVC.

The following table shows the actuarial values determined by the AVC, and the adjusted actuarial values that Wakely is certifying after the application of the adjustment factor.

Standard Plan	AV from AVC	Adjusted AV	Adjustment Factor
Standard Gold	82.60%	81.89%	0.9914
Standard Silver	72.06%	71.21%	0.9882
Standard Silver, 73% AV CSR Variation	74.17%	73.34%	0.9888
Standard Silver, 87% AV CSR Variation	88.21%	87.60%	0.9931
Standard Silver, 94% AV CSR Variation	94.70%	94.42%	0.9970
Standard Bronze	64.46%	64.29%	0.9973

Disclosures and Limitations

Responsible Actuary. Brittney Phillips is the actuary responsible for this communication. Brittney is a member of the American Academy of Actuaries and is an Associate of the Society of Actuaries. She meets the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended Users. This information has been prepared for the use of WAHBE and WAHBE exchange plan issuers. Wakely does not intend to benefit third parties and assumes no duty or liability to those third parties. Any third parties receiving this work should consult their own experts in interpreting the results.

This report, when distributed, must be provided in its entirety and include caveats regarding the variability of results and Wakely's reliance on information provided by WAHBE.

Risks and Uncertainties. The assumptions and resulting estimates included in this report are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from any estimates. Wakely does not warrant or guarantee that actual experience will tie to the AV estimated for the placement of plan designs into tiers. The developed actuarial values are for the purposes of classifying plan designs of similar value and do not represent the expected actuarial value of a plan or pricing AV used to determine premium rates. Actual AVs will vary based on a plan's specific population, utilization, unit cost, and other variables. It is the responsibility of the organization receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. Wakely provides actuarial services to a variety of clients throughout the health industry. Our clients include commercial, Medicare, and Medicaid health plans, the federal government and state governments, medical providers, and other entities that operate in the domestic and international health insurance markets. Wakely has implemented various internal practices to reduce or eliminate conflict of interest risk in serving our various clients. Except as noted here, the responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent from WAHBE.

Data and Reliance. Wakely relied on information supplied by WAHBE in this assignment. We have reviewed the data for reasonableness but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly. Any errors in the data will affect the accuracy of the analysis and the conclusions drawn in this report. When performing financial and actuarial analyses on the current data, assumptions must be made where there is incomplete data. Improvements in data will allow for more accurate analyses and consistent reporting. Below is a list of data and assumptions provided by others and assumptions required by law.

- The Final 2022 Federal AVC Model was relied on for the original AV. While reasonability tests have shown there are some assumptions and methodologies that are not consistent with expectations, the AVC was developed for plan classification and not pricing. Thus, the model is being used as such and we make no warranties for the accuracy of the AVs that result from the AVC.

Subsequent Events. There are no other known relevant events subsequent to the date of information received that would impact the results of this report.

Contents of Actuarial Report. This document and the supporting exhibits constitute the entirety of the actuarial report and supersede any previous communications on the project.

Deviations from ASOPS. Wakely completed the analysis using sound actuarial practice. To the best of our knowledge, the report and methods used in the analysis are in compliance with the appropriate Actuarial Standards of Practice (ASOP) with no known deviations. In developing these standard plan designs and the resulting actuarial certification, Wakely followed applicable Actuarial Standards of Practice (ASOP) including:

- ASOP No. 23 Data Quality;
- ASOP No. 25 Credibility Procedures;
- ASOP No. 41 Actuarial Communications;
- ASOP No. 50 Determining Minimum Value and Actuarial Value under the Affordable Care Act; and
- ASOP No. 56 Modeling.

Appendix A contains the formal actuarial certification. If you have any questions regarding this letter or the certification, please contact us.

Sincerely,

Brittney Phillips, ASA, MAAA
Senior Consulting Actuary

Appendix A

Adjusted Actuarial Value Certification

Washington Health Benefit Exchange Standard Plan Designs Effective January 1, 2022

I, Brittney Phillips, am associated with the firm of Wakely Consulting Group, LLC. (Wakely), am an Associate of the Society of Actuaries and a member of the American Academy of Actuaries, and meet its Qualification Standards for Statements of Actuarial Opinion. Wakely was retained by Washington Health Benefit Exchange (WAHBE) to provide a certification of the adjusted actuarial value of the standard plan designs offered through WAHBE that are effective January 1, 2022. This certification may not be appropriate for other purposes.

To the best of my information, knowledge and belief, the adjusted actuarial values provided with this certification are considered actuarially sound for purposes of 45 CFR § 156.135(b), according to the following criteria:

- The final 2022 federal Actuarial Value Calculator was used to determine the AV for the plan provisions that fit within the calculator parameters;
- Appropriate adjustments were calculated, to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV calculator;
- The actuarial values have been developed in accordance with generally accepted actuarial principles and practices; and
- The actuarial values meet the requirements of 45 CFR § 156.135(b).

The assumptions and methodology used to develop the actuarial values have been documented in this report. The actuarial values associated with this certification are for the 2022 WAHBE standard plan designs with unique designs that could not be accommodated by the AV Calculator that will be effective as of January 1, 2022 for individual coverage sold on the Washington Health Benefit Exchange.

The developed actuarial values are for the purposes of classifying plan designs of similar value and do not represent the expected actuarial value of a plan. Actual AVs will vary based on a plan's specific population, utilization, unit cost and other variables.

In developing the actuarial values, I have relied upon the federal Actuarial Value calculator.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time-to-time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

Brittney Phillips, ASA, MAAA
Senior Consulting Actuary, Wakely Consulting Group, LLC
May 10, 2021

Appendix B

Actuarial Value Certification

Unique Plan Design Supporting Documentation and Justification

Applicable Plans: 2022 Standard Gold, Silver Copay Standard CSR Variation, the 73% CSR, the 87% CSR, the 94% CSR and the Bronze non-HSA Standard Option

Reasons the plan design is unique (benefits that are not compatible with the parameters of the AV calculator, and the materiality of those benefits): copays applied for services that are not subject to deductible, and copay does not accrue toward deductible.

The AVC accrues any copays applied during the deductible period toward the deductible. The standard plan designs include services that are not subject to the deductible and that include copays. The copays paid during the deductible period do not accrue toward the deductible.

For the Bronze Standard Option, Mental Health and Substance User Disorder Outpatient Services have different cost sharing for office visits and all other services. The AVC combines these services and only allows a single input for these services.

We have applied an adjustment to the AV calculated in the AVC after entering the plan parameters that do fit the AVC.

Acceptable alternate method used per 156.135(b) (2) or 156.135(b) (3): Method 156.135(b) (3) was utilized in developing the actuarial values for the plans.

Confirmation that only in-network cost-sharing, including multitier networks, was considered: Only in-network cost-sharing was considered in the development of the actuarial values.

Description of the standardized plan population data used: The standardized plan population data used in the analysis was derived from the Wakely proprietary database of ACA individual and small group experience for 2017.

If the method described in 156.135(b) (2) was used, a description of how the benefits were modified to fit the parameters of the AV calculator:

If the method described in 156.135(b) (3) was used, a description of the data and method used to develop the adjustments: Wakely utilized a proprietary data set reflecting nationwide ACA individual market experience from 2017 to develop a readjudication model that sequentially

runs the detailed claims data for an individual and a family through logic to calculate the respective cost sharing that an individual would owe and the portion of a claim that would be paid by the insurer. This includes accumulation of cost sharing that accrues to the deductible as well as cost sharing accruing to the overall maximum out of pocket limits for a plan. The model was set up to reflect the cost sharing structure for the specific plan designs for the applicable plans above. The following steps were taken to formulate our adjustment by plan:

For the Gold and Silver Standard plans (including CSR variants as applicable), we calculated the actuarial value in two benefit situations. The first was calculated allowing the copays paid for services that are not subject to the deductible to also accrue to the deductible before the deductible is met. The second actuarial value was calculated without allowing the copays to accrue to the deductible. All other services were run in accordance with the AVC, including whether the medical and pharmacy deductibles are combined or separate. We then took the difference in AV's to calculate an adjustment factor. This factor was applied to the actuarial value that was calculated by the AV Calculator with benefits input as completely as possible.

For the Bronze Standard Option, we calculated the actuarial value in two benefit situations. The first was calculated allowing the copays paid for services that are not subject to the deductible to also accrue to the deductible before the deductible is met. Also, All MH/SUD outpatient services applied the same copay as primary care office visits, regardless of the place of service. The second actuarial value was calculated without allowing the copays to accrue to the deductible and MH/SUD outpatient services not in an office setting were updated to reflect being subject to the deductible and applying the standard coinsurance rate. All other services were run in accordance with the AVC, including whether the medical and pharmacy deductibles are combined or separate. We then calculated an adjustment factor equal to the actuarial value without copays accruing to the deductible and a single MH/SUD outpatient benefit divided by the actuarial value with copays accruing to the deductible and separate MH/SUD outpatient cost sharing. This factor was applied to the actuarial value that was calculated by the AV Calculator with benefits input as completely as possible.

Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b) (2) or 156.135(b) (3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV.

The analysis was

(i) conducted by a member of the American Academy of Actuaries; and

(ii) performed in accordance with generally accepted actuarial principles and methodologies.

Actuary signature:

Actuary Printed Name: Brittney Phillips, ASA, MAAA

Date: May 10, 2021

If this provides insufficient space to list your justifications, please print out another form and add additional reasons there.

Appendix C

WAHBE 2022 Standard Plan Designs
Individual Market Gold, Silver, and Bronze Plans

Benefits	Standard Gold	Standard Silver	Standard Bronze
Medical/Pharmacy Integrated Deductible	No	Yes	Yes
Medical/Pharmacy Integrated MOOP	Yes	Yes	Yes
Medical (or Integrated, if Applicable) Deductible ($)	$500	$2,000	$6,000
Pharmacy Deductible ($)	$0	N/A	N/A
Medical/Pharmacy Integrated MOOP ($)	$5,250	$7,800	$8,550
Emergency Care Services	$450	$800	40%
Urgent Care	$35	$60	$100
All Inpatient Hospital Services (inc. MH/SUD,Maternity)	$525*	$800*	40%
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	$15	$25	$50
Specialist Visit	$40	$60	$100
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Office Visits	$15	$25	$50
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other	$15	$25	40%
Advanced Imaging (CT/PET Scans, MRIs)	$300	30%	40%
Speech Therapy	$25	$35	40%
Occupational and Physical Therapy	$25	$35	40%
Preventive Care/Screening/Immunization	$0	$0	$0
Laboratory Outpatient and Professional Services	$20	$35	40%
X-rays and Diagnostic Imaging	$30	$60	40%
Skilled Nursing Facility	$350 **	$800 **	40%
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$350	$600	40%
Outpatient Surgery Physician/Surgical Services	$75	$200	40%
Generics	$10	$20	$32
Preferred Brand Drugs	$60	$70	40%
Non-Preferred Brand Drugs	$100	$250	40%
Specialty Drugs (i.e. high-cost)	$100	$250	40%
Ambulance	$375	$375	40%
Routine Eye Exam for Children	$0	$0	$0
All Other Benefits	20%	30%	40%
Federal AV from AVC	**82.60%**	**72.06%**	**64.46%**
Adjustment Factor	0.9914	0.9882	0.9973
Adjusted AV * **	**81.89%**	**71.21%**	**64.29%**

Shaded items are not subject to deductible.

* Per day copay, limit of 5 copays per stay; ** Per day copay; *** Adjusted AV reflects unique plan design in which copays do not accumulate to deductible. For the Standard Bronze plan, it also includes the different MH/SUD outpatient services cost sharing for office visits and other services.

Individual Market Silver Plan and CSR Variations

Benefits	Standard Silver	Standard Silver 73% AV	Standard Silver 87% AV	Standard Silver 94% AV
Medical/Pharmacy Integrated Deductible	Yes	Yes	No	No
Medical/Pharmacy Integrated MOOP	Yes	Yes	Yes	Yes
Medical (or Integrated, if Applicable) Deductible ($)	$2,000	$2,000	$750	$150
Pharmacy Deductible ($)	N/A	N/A	$0	$0
Medical/Pharmacy Integrated MOOP ($)	$7,800	$6,500	$2,250	$800
Emergency Care Services	$800	$750	$425	$150
Urgent Care	$60	$60	$30	$15
All Inpatient Hospital Services (inc. MH/SUD,Maternity)	$800*	$750*	$425*	$100*
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	$25	$20	$10	$3
Specialist Visit	$60	$60	$30	$15
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Office Visits	$25	$20	$10	$3
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other	$25	$20	$10	$3
Advanced Imaging (CT/PET Scans, MRIs)	30%	30%	20%	15%
Speech Therapy	$35	$35	$20	$5
Occupational and Physical Therapy	$35	$35	$20	$5
Preventive Care/Screening/Immunization	$0	$0	$0	$0
Laboratory Outpatient and Professional Services	$35	$35	$20	$5
X-rays and Diagnostic Imaging	$60	$60	$40	$15
Skilled Nursing Facility	$800 **	$750 **	$425 **	$100 **
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$600	$600	$325	$100
Outpatient Surgery Physician/Surgical Services	$200	$175	$120	$25
Generics	$20	$18	$12	$3
Preferred Brand Drugs	$70	$70	$35	$12
Non-Preferred Brand Drugs	$250	$200	$160	$35
Specialty Drugs (i.e. high-cost)	$250	$200	$160	$35
Ambulance	$375	$325	$175	$75
Routine Eye Exam for Children	$0	$0	$0	$0
All Other Benefits	30%	30%	20%	15%
Federal AV from AVC	**72.06%**	**74.17%**	**88.21%**	**94.70%**
Adjustment Factor	0.9882	0.9888	0.9931	0.9970
Adjusted AV * **	**71.21%**	**73.34%**	**87.60%**	**94.42%**

Shaded items are not subject to deductible.

* Per day copay, limit of 5 copays per stay; ** Per day copay; *** Adjusted AV reflects unique plan design in which copays do not accumulate to deductible. For the Standard Bronze plan, it also includes the different MH/SUD outpatient services cost sharing for office visits and other services.

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 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 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:
    a. Chiropractic: 10 visits
    b. Acupuncture: 12 visits
    c. Home Health Care Services: 130 days
    d. Hospice respite services: 14 days per lifetime
    e. Outpatient rehabilitation, combined physical, occupational, and speech therapy, services: 25 visits
    f. Outpatient habilitation services: 25 visits
    g. Inpatient rehabilitative services: 30 days
    h. 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. 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 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 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.

Appendix D

WAHBE 2022 AVC Screenshots (Unadjusted)

(Begins on next page)

Individual Market Standard Gold Plan

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$500.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	80.00%				
MOOP ($)	$5,250.00					
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☑	☐		$450.00	☐	☐			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☐	☐		$525.00	☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$15.00	☐	☐			☐	☐
Specialist Visit	☐	☐		$40.00	☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$15.00	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$300.00	☐	☐			☑	☐
Speech Therapy	☐	☐		$25.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$25.00	☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☐	☐			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$30.00	☐	☐			☐	☐
Skilled Nursing Facility	☑	☐		$350.00	☐	☐			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$350.00	☐	☐			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$75.00	☐	☐			☑	☐
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☑	☐		$10.00	☐	☐			☑	☐
Preferred Brand Drugs	☑	☐		$60.00	☐	☐			☑	☐
Non-Preferred Brand Drugs	☑	☐		$100.00	☐	☐			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☐		$100.00	☐	☐			☑	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	5
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: Standard Gold
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2022_1b

Output

Calculate

Status/Error Messages: Error: Result is outside of [-4, +2] percent de minimis variation.
Actuarial Value: 82.60%
Metal Tier:

NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.1797 seconds
Final 2022 AV Calculator

Individual Market Standard Silver Plan

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
MOOP ($)			$7,800.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☑	☐		$800.00	☐	☐			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$800.00	☐	☐			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$25.00	☐	☐			☐	☐
Specialist Visit	☐	☐		$60.00	☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$25.00	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑		$0.00	☐	☐			☐	☐
Speech Therapy	☐	☐		$35.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$35.00	☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$35.00	☐	☐			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$60.00	☐	☐			☐	☐
Skilled Nursing Facility	☑	☐		$800.00	☐	☐			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$600.00	☐	☐			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$200.00	☐	☐			☑	☐
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☐	☐		$20.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$70.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☐		$250.00	☐	☐			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☐		$250.00	☐	☐			☑	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐	
Specialty Rx Coinsurance Maximum:		
Set a Maximum Number of Days for Charging an IP Copay?	☑	
# Days (1-10):	5	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐	
# Visits (1-10):		
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:

Name: Standard Silver
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2022_1b

Output

Calculate

Status/Error Messages: Error: Result is outside of [-4, +2] percent de minimis variation.
Actuarial Value: 72.06%
Metal Tier:

NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.2812 seconds
Final 2022 AV Calculator

Individual Market Standard Silver, CSR 73% Plan

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
MOOP ($)			$6,500.00			
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☑	☐		$750.00	☐	☐			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$750.00	☐	☐			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☐	☐			☐	☐
Specialist Visit	☐	☐		$60.00	☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$20.00	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑		$0.00	☐	☐			☐	☐
Speech Therapy	☐	☐		$35.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$35.00	☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$35.00	☐	☐			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$60.00	☐	☐			☐	☐
Skilled Nursing Facility	☑	☐		$750.00	☐	☐			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$600.00	☐	☐			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$175.00	☐	☐			☑	☐
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☐	☐		$18.00	☐	☐			☐	☐
Preferred Brand Drugs	☐	☐		$70.00	☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☐		$200.00	☐	☐			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☐		$200.00	☐	☐			☑	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	5
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: Standard Silver 73% AV
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2022_1b

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value: 74.17%
Metal Tier:

Additional Notes: NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Calculation Time: 0.2812 seconds
Final 2022 AV Calculator

Individual Market Standard Silver, CSR 87% Plan

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$750.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	80.00%				
MOOP ($)	$2,250.00					
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☑	☐		$425.00	☐	☐			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$425.00	☐	☐			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☐	☐			☐	☐
Specialist Visit	☐	☐		$30.00	☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$10.00	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑		$0.00	☐	☐			☐	☐
Speech Therapy	☐	☐		$20.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$20.00	☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$20.00	☐	☐			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$40.00	☐	☐			☐	☐
Skilled Nursing Facility	☑	☐		$425.00	☐	☐			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$325.00	☐	☐			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$120.00	☐	☐			☑	☐
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☑	☐		$12.00	☐	☐			☑	☐
Preferred Brand Drugs	☑	☐		$35.00	☐	☐			☑	☐
Non-Preferred Brand Drugs	☑	☐		$160.00	☐	☐			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☐		$160.00	☐	☐			☑	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐	
Specialty Rx Coinsurance Maximum:		
Set a Maximum Number of Days for Charging an IP Copay?	☑	
# Days (1-10):	5	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐	
# Visits (1-10):		
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:

Name: Standard Silver 87% AV
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2022_1b

Output

Calculate

Status/Error Messages: Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value: 88.21%
Metal Tier:

NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).

Additional Notes:

Calculation Time: 0.2266 seconds
Final 2022 AV Calculator

Individual Market Standard Silver, CSR 94% Plan

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☑
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$150.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	85.00%	85.00%				
MOOP ($)	$800.00					
MOOP if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☐	☐		$150.00	☐	☐			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$100.00	☐	☐			☑	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$3.00	☐	☐			☐	☐
Specialist Visit	☐	☐		$15.00	☐	☐			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$3.00	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑		$0.00	☐	☐			☐	☐
Speech Therapy	☐	☐		$5.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$5.00	☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$5.00	☐	☐			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$15.00	☐	☐			☐	☐
Skilled Nursing Facility	☑	☐		$100.00	☐	☐			☑	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$100.00	☐	☐			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☐		$25.00	☐	☐			☑	☐
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☑	☐		$3.00	☐	☐			☑	☐
Preferred Brand Drugs	☑	☐		$12.00	☐	☐			☑	☐
Non-Preferred Brand Drugs	☑	☐		$35.00	☐	☐			☑	☐
Specialty Drugs (i.e. high-cost)	☑	☐		$35.00	☐	☐			☑	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐	
Specialty Rx Coinsurance Maximum:		
Set a Maximum Number of Days for Charging an IP Copay?	☑	
# Days (1-10):	5	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐	
# Visits (1-10):		
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:

Name: Standard Silver 94% AV
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2022_1b

Output

Calculate

Status/Error Messages: CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value: 94.70%
Metal Tier: Platinum
Additional Notes: NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Calculation Time: 0.1953 seconds

Final 2022 AV Calculator

Individual Market Standard Bronze Plan

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☑
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:	$0.00	1st Tier Utilization:	100%
		2nd Tier Utilization:	0%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
MOOP ($)			$8,550.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	☑	☑			☐	☐			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☐	☐			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$50.00	☐	☐			☐	☐
Specialist Visit	☑	☐		$100.00	☐	☐			☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$50.00	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☑	☑			☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑			☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☐	☐			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☐	☐			☐	☐
Skilled Nursing Facility	☑	☑			☐	☐			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☐			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☐			☐	☐
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics	☐	☐		$32.00	☐	☐			☐	☐
Preferred Brand Drugs	☑	☑			☐	☐			☐	☐
Non-Preferred Brand Drugs	☑	☑	60%		☐	☐			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☐	☐			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: Standard Bronze
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2022_1b

Output

Calculate

Status/Error Messages:	Expanded Bronze Standard (56% to 65%), Calculation Successful.
Actuarial Value:	64.46%
Metal Tier:	Bronze
	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Additional Notes:	
Calculation Time:	0.2344 seconds

Final 2022 AV Calculator