April 15, 2024

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

RE: CERTIFICATION FOR WAHBE 2025 STANDARD PLAN DESIGNS

At the request of the Washington Health Benefit Exchange (WAHBE), Wakely is providing an actuarial value (AV) certification and unique plan justification for the 2025 standardized plan designs. The 2025 benefit designs were modestly adjusted to fit within the parameters of the final 2025 federal AV calculator's (AVC) constraints and to include special cost sharing for office visits for primary care and mental health/substance use disorder (MH/SUD). For 2025, Acumen modified the 2025 standardized plan designs to fit within the actuarial value requirements and made adjustments to the federal AVC for unique plan designs that did not fit into the AVC and could be considered material. Wakely completed a review of Acumen's methodology, conducted reasonability checks, and is certifying the unique plan adjustments and plan actuarial values.

While this memo discusses Acumen's methodology at a high level, it primarily focuses on review completed by Wakely to confirm the reasonability of Acumen's AV estimates. Wakely is providing an actuarial certification for the adjusted actuarial values allowed under 45 CFR §156.135(b) (3) in Appendices A and B. The documentation that Acumen provided on their methodology can be found in the Appendix C.

Our understanding is that WAHBE will use the final certification for plan year 2025. Use of this document for other purposes may not be appropriate. This document, and any accompanying files and correspondence, are intended for WAHBE internal use only and are not meant for broad distribution. The estimates presented here are based on emerging data and information available as of the date of this report.

This memo should only be utilized by qualified individuals with an understanding of the assumptions and limitations of the analysis described in the disclosures section of the memo. If disseminated, the memo should only be shared in its entirety. During the review of the memo, if you should have any questions or would like further clarification, please do not hesitate to contact us via email or phone (contact information available below), and we will be happy to provide assistance.

wakely.com

Washington Health Benefit Exchange

2025 Standard Plans Actuarial Value Certification and Unique Plan Design Supporting Documentation and Justification

April 15, 2024

Prepared by:
Wakely Consulting Group, LLC

Ksenia Whittal, FSA, MAAA
Senior Consulting Actuary
Darren Johnson, FSA, MAAA
Consulting Actuary

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Background

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 actuarial values that fall under the platinum (90% AV), gold (80% AV), silver (70% AV) or bronze (60% AV) tiers. The ACA allows for a de minimis range around these target AVs. The final 2025 NBPP did not make any changes to the allowable federal AV range relative to the 2024 NBPP, however final 2025 NBPP parameters are listed here for completeness. The final 2025 NBPP finalized a range of -2% to +2% for most plans. For example, any plan design that has an AV from 78% to 82% is considered a gold plan. Similar to the final 2024 NBPP, the final 2025 NBPP is proposing a smaller range on the lower end for on-Exchange silver plans of 0% to +2% (or an AV between 70% and 72%). Off-Exchange silver plans would continue to be subject to the -2% to +2% range. Bronze plan designs meeting certain criteria are eligible for an expanded range of +5% on the higher end, allowing an AV up to 65% compared to a high end at 62%. Plans that meet these criteria include high deductible health plans and plans that cover at least one major service, other than preventive, prior to the deductible.

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 final 2025 NBPP allows for a 0% to +1% de minimis range around the target AVs for CSR plans (e.g., 73% to 74% AV for a 73% CSR plan). The plan designs developed by Acumen for 2025 comply with this proposed 2025 AV ranges.

The Center for Consumer Information and Insurance Oversight (CCIIO) provides an Actuarial Value Calculator (AVC)[1] 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 2025, WAHBE is defining one standard plan design for the individual market for the gold, silver (and three corresponding CSR plan levels), and expanded bronze levels. This is consistent with 2024.

WAHBE contracted with Acumen to assist with the development and validation of the

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

federal AVs for the 2025 standard plan designs. WAHBE contracted with Wakely to assist in reviewing Acumen's development of the 2025 standard plan designs for reasonability and to certify actuarial values of all standard plan designs, including any unique plan designs. Standard expanded bronze, silver and all silver CSR variants are considered to be unique plan designs. Compliance of the benefit designs in relation to other regulatory benefit design constraints has not been evaluated by Wakely.

For the 2025 standard plans, benefit changes were made to the 2024 standard plans to account for the updates made to the final 2025 federal AV calculator. The changes within the final 2025 AV calculator include a change in data source from group data to ACA data (from the External Data Gathering Environment (EDGE) as the source). In addition, the threshold used to exclude outlier members was reduced from the 99.9th percentile of cost to the 99.5th percentile. These updates had varying impacts by metal level. 2025 standard plan designs reflect design changes requested by WAHBE and necessary updates made to remain compliant with the final 2025 federal AV calculator.

A summary of WAHBE's standard plan designs is in Appendix D. Most of the cost sharing features of 2025 standard plan designs can be accommodated by the final federal AVC. However, the plan designs have features not supported by the AVC (defined as a "unique" plan design). The unique plan designs features are:

1. Mixed cost sharing applied to Mental Health/Substance Use Disorder (MH/SUD) outpatient services. The expanded bronze standard plan design specifies that MH/SUD services provided in an office setting will incur a copay, but other outpatient MH/SUD services (non-office visit) will be subject to the deductible and 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 also constitutes a unique benefit design.
2. The first two PCP and MH/SUD office visits have a $1 copay. Expanded bronze and silver standard designs (including CSR variants) include a provision for a $1 copay for the first two PCP office visits and MH/SUD office visits. Since the AVC does not have the functionality to accommodate this design feature, this also constitutes a unique benefit design.

The adjustment made to the AVC by Acumen addresses both unique plan designs features and is described below. A summary of WAHBE's 2025 standard plan designs is included in Appendix D.

Methodology

Wakely is providing an actuarial certification for all standard plan designs, including those that utilize adjusted actuarial values allowed under 45 CFR § 165.135(b)(3) in

Appendices A and B. Acumen utilized the final 2025 federal AVC to determine the AV for all plans, entering plan designs to the extent that they fit the AVC. Screen shots of the unadjusted AVC inputs and outputs for plan designs that were accommodated by the AVC and the adjusted AVC screenshots provided and developed by Acumen can both be found in Appendix E. The first set of screenshots displays outputs from the final 2025 AVC for each standard plan design. The second set of screenshots, captioned as "Adjusted", displays output from a custom modified version of the AVC constructed using the methodology described briefly below and in more detail in Appendix C.

The gold standard plan has no features deviating from the parameters of the AVC and was entered by Acumen into the AVC with no modifications. Acumen adjusted the other resulting AVs for the plan design features that deviate from the parameters of the AVC. For the expanded 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. For the expanded bronze and silver standard plans (including all CSR variants), the AVC does not accommodate plan designs with a specified number of upfront $1 copay visits for MH/SUD visits or for primary care visits. The adjustment that Acumen calculated to account for both unique benefit features is described below.

To modify the AVC to account for the first two PCP and MH/SUD visits prior to the enrollee being responsible for a higher copay, Acumen modified the AVC continuance tables. In the medical and combined continuance tables in the AVC, Acumen estimated the proportion of utilization and allowed cost attributable to MH/SUD in an office setting and combined the MH/SUD office visits with primary care office visits utilization and allowed cost. Acumen then modified the cost and frequency columns associated with the number of primary care visits exceeding a specified number of visits by applying the original ratio of these quantities to total primary care columns to the modified primary care columns including MH/SUD office visits amounts. The main assumption made by Acumen is that the number of MH/SUD office visits exceeding a specified number of visits will follow a similar distribution as the primary care visits. Data analyzed by Wakely in the past showed that the large portion of the primary care office visits utilization is between 1-2 visits per year. For MH/SUD office visits services, while utilization is lower due to fewer members seeking the services; however, for members that do use services, the number of services exceed 1-2 per year. The assumption made by Acumen that the distributions are similar results in a larger impact to the AV than it otherwise would, as $1 copay would apply to a higher proportion of the total MH/SUD visits, thus resulting in a higher calculated AV than we think is likely to actually occur. Since the sensitivity testing Wakely performed considered the lower and the upper bounds of a reasonable AV range and found the adjusted AV falling in the compliant range, this assumption would not alter the AV categorization of the plans except for the Silver 73% CSR plan, which is discussed more later in this certification.

The AVC field "Begin Primary Cost-Sharing After a Set Number of Visits" effectively

became “Begin Primary and MH/SUD Cost-Sharing After a Set Number of Visits” with this change, along with revising the $0 copay associated with this feature to a $1 copay. Acumen used the version of the AVC with revised continuance tables to calculate the adjusted AVs. This change was only made for the expanded bronze, silver, and silver CSR variants standard plans since the first two $1 copay PCP and MH/SUD visits feature does not apply to the gold standard plan.

Table 1 shows the actuarial values determined by the original federal final 2025 AVC, including the unadjusted actuarial value for the standard gold plan that Wakely is certifying and the adjusted actuarial values for the standard silver, standard silver CSR variants, and standard expanded bronze plans, that Acumen calculated and Wakely is certifying after the application of the adjustment factor.

Table 1 – Summary of Original and Adjusted Federal AVs

Standard Plan	AV from Original AVC	AV from Acumen Adjusted AVC	Adjustment Factor
Standard Gold (no adjustment needed)	81.39%		
Standard Silver*	70.39%	70.75%	1.005
Standard Silver, 73% AV CSR Variation*	72.94%**	73.28%	1.005
Standard Silver, 87% AV CSR Variation*	87.83%	87.89%	1.001
Standard Silver, 94% AV CSR Variation*	94.69%	94.73%	1.000
Standard Expanded Bronze*	62.42%	63.64%	1.020

** Note that the AVs in this column were developed with two upfront no-cost PCP visits.*

*** Note that the unadjusted AV is outside of the de minimis range allowed for the Silver 73% CSR plan variant.*

Wakely believes that the methodology that Acumen used to adjust the AVs is appropriate based on the reasonability testing of Acumen’s adjusted AVs. To determine whether the adjusted AVs were reasonable, Wakely tested three alternative plan designs in the original AVC that would serve as the boundary cases for the adjusted AVs. The expectation was that the adjusted AV should fall within the range of AVs produced by these alternative boundary cases. Wakely ran this test for all standard plans that offer the two MH/SUD $1 copay visits (all except gold). Only two boundary designs were needed for all plans other than expanded bronze.

The three alternative boundary plan designs used to test the reasonable AV range were as follows:

1. 2025 standard plan designs for each metal, with the same cost sharing applied to all PCP and outpatient MH/SUD services. For the expanded bronze plan design, two lower boundary designs were included:

    (a) a design with the deductible and coinsurance cost sharing applied to all outpatient MH/SUD services; and

    (b) a design with $50 copay cost sharing applied to all PCP visits and outpatient MH/SUD services.

2. 2025 standard plan designs for each metal, with $0 cost-sharing applied to first two PCP visits and all outpatient MH/SUD services. This is a richer boundary case than $1 copay, but the AVC does not allow for a $1 copay for initial visits. As such, this provides the closest boundary case within the design of AV calculator.

Wakely modeled each of these plan designs in the 2025 federal final AV calculator. For the bronze plans, the AV for the mixed cost sharing applied to outpatient MH/SUD services (copay for office visits and deductible and coinsurance for all other services) would be a weighted average of the two AVs produced in (1a) and (1b). The resulting AVs are presented in the Table 2 below.

For all plans above, Acumen's 2025 adjusted AV falls within the AV range produced by the lower and upper boundary plan designs. For bronze plan, the adjusted actuarial value exceeds both lower bound AVs with different types of cost sharing applied to all MH/SUD outpatient services (copays and deductible / coinsurance). Considering the range of AVs created by these two plans was narrow and considering that the adjusted AV logically fell within this range, Wakely deemed the adjusted AVs calculated by Acumen to be reasonable and actuarially sound.

Table 2 – Summary of Original and Adjusted Federal AVs

Standard Plan	2025 Adjusted AV	Low Boundary Plan/s (Standard Copays on all PCP and MH/SUD Visits)	Upper Boundary Plan (Zero Cost Sharing on all MH/SUD Visits and Two PCP Visits)
Standard Silver	70.75%	70.02%	71.18%
Standard Silver, 73% AV CSR Variation	73.28%	72.61%	73.68%
Standard Silver, 87% AV CSR Variation	87.89%	87.74%	87.98%
Standard Silver, 94% AV CSR Variation	94.73%	94.64%	94.82%
Standard Bronze (a) – Ded/Coins for MH/SUD	63.64%	61.67%	64.41%
Standard Bronze (b) – Copay for MH/SUD	63.64%	62.47%	64.41%

Note that while the lower bound of silver CSR 73% variation AV falls below the de minimis range minimum at 72.61%, the application of $1 copay on the first two PCP and MH/SUD visits (rather than a $30 copay on all MH/SUD visits and 3+ PCP visits) would likely increase the plan richness and the AV above the 73.00% minimum.

To test this conclusion, Wakely tested an alternative design by calculating a blended best estimate PCP and MH/SUD copay. We used a percentage of utilization of PCP office visit utilization for the first two visits (56.0% based on silver combined claim probability distribution (CPD) for PCP utilization[2]) and the percentage of OP MH/SUD utilization that is office visits (76.1% based on Acumen estimates and the AV Calculator CPD)[3] as the starting point.

As discussed above, for this plan the Acumen assumption around MH/SUD annual utilization could potentially be impactful, as we think that assumption overstates AVs versus actual experience which will have a lower percentage of office visits be the first two for a member in a given year. We found a revised assumption for that percentage by utilizing our WACA 2019 ACA Data (see Data and Reliance section) to calculate the proportion of MH/SUD office visit utilization that takes place in a member's first two visits (24.1%).

Using these assumptions, a revised blended cost sharing was used for a PCP visit of

[2] 56.0% was calculated by taking the ratio of the final value in the "Silver Combined" sheet PCP Silver Frequency column (J170) and the final value in the "Primary Care >2 Visits" column (CF170) to get the proportion of PCP visits that are the first two visits a member has.

[3] Acumen stated that 78.5% of professional MH/SUD services were office visits and 12.7% of facility MH/SUD services were office visits. Using the AVC Silver Combined sheet cells AV170 and AX170 for MH/SUD facility/professional utilization split, we can see that 96.3% of total MH/SUD visits come from professional services with the remaining 3.7% coming from facility services. Taking the sum-product of those numbers gives us 76.1% of MH/SUD services that are office visits (96.3% x 78.5% + 3.7% x 12.7%).

$13.76 ($1 x 56.0%+$30 x (1-56.0%)) and MH/SUD copay of $24.68 ($1 x 24.1% + $30 x (1-24.1%)) x 76.1% + $30 x (1-76.1%), yielding an actuarial value of 73.02%, which represents our best estimate actuarial value for this plan and is above the 73.00% threshold.

Disclosures and Limitations

Responsible Actuary. Ksenia Whittal and Darren Johnson are the actuaries responsible for this communication. We are members of the American Academy of Actuaries and Fellows of the Society of Actuaries. We meet 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, Washington Office of the Insurance Commissioner (OIC), Acumen and WAHBE 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 actuary is 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 and Acumen.

Data and Reliance. Wakely relied on information supplied by Acumen and WAHBE in this assignment. Wakely has reviewed the data and methodology for reasonableness but has

not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, these 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 2025 final federal AVC Model was relied on for the AV calculations. 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 Wakely makes no warranties for the accuracy of the AVs that result from the AVC.
- The AVC adjustment methodology provided and developed by Acumen (included in Appendix C).
- The unadjusted and adjusted AVC screenshots provided and developed by Acumen (included in Appendix E).
- 2025 WAHBE standard plan benefit designs provided by WAHBE (included in Appendix D).

In addition, we relied on the Wakely ACA Database (WACA) for our MH/SUD visit assumption. This is an aggregated database based on de-identified EDGE Server input and output files (including enrollment, claims, and pharmacy data) from the 2019 benefit year submitted through April 2020, along with supplemental risk adjustment transfer and issuer-reported financial information, representing approximately 4 million lives from the individual and small group ACA markets. The de-identification applies to identifiers specific to enrollee, issuer, and location. We performed reasonability tests on the data but did not audit or verify the data.

Potential limitations of the WACA data include but are not limited to the following:

- Results will be affected by issuer-specific data management. Omitted claims, erroneously coded claims, erroneous enrollment records, and other data issues may not reflect actual ACA cost and diagnosis experience.

- A subset of issuers nationwide submitted data to the database. We believe the database represents a fair cross-section of nationwide experience, but limitations in this regard will affect results.

- We excluded data for both enrollees in American Indian (limited/no-cost sharing) CSR plans and enrollees in Medicaid Private Option plans (these only occur in a few states).

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 my 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,

Ksenia Whittal, FSA, MAAA
Senior Consulting Actuary
720-282-4965

Darren Johnson, FSA, MAAA
Consulting Actuary
720-206-1391

Appendix A - Actuarial Value Certification

Washington Health Benefit Exchange Standard Plan Designs Effective January 1, 2025

I, Ksenia Whittal, am associated with the firm of Wakely Consulting Group, LLC, an HMA Company (Wakely), am a Fellow 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, 2025. 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 2025 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 2025 WAHBE standard expanded bronze, silver, silver 73% CSR, silver 87% CSR, silver 94% CSR and gold plan designs that will be effective as of January 1, 2025 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 this opinion, I have relied upon the final federal Actuarial Value calculator and the adjustment methodology provided by Acumen. 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.

Ksenia Whittal, FSA, MAAA
Senior Consulting Actuary
Wakely Consulting Group, LLC, an HMA Company
April 15, 2024

Appendix B - Unique Plan Design Supporting Documentation and Justification

Applicable Plans: 2025 Standard Silver, the Silver 73% CSR, the Silver 87% CSR, the Silver 94% CSR and the Expanded Bronze 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): For the Expanded Bronze Standard Option, Mental Health and Substance Use 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. For the Expanded Bronze, Silver, Silver 73% CSR, Silver 87% CSR, and Silver 94% CSR plans, there is a $1 copay for the first two primary care and Mental Health and Substance Use Disorder Outpatient office visits. The AVC input does not accommodate this feature.

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: Acumen used the data underlying the continuance tables in the 2025 federal AV calculator.

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: n/a

If the method described in 156.135(b) (3) was used, a description of the data and method used to develop the adjustments: Acumen developed adjustments to the continuance tables in AVC to accommodate the unique plan design features. Wakely did not replicate these changes but rather performed reasonability testing of Acumen's methodology by testing three sets of alternative plan designs in the original AVC that would serve as the boundary cases for the adjusted AVs. The expectation was that the adjusted AV should fall within the range of AVs produced by these alternative boundary cases. Wakely tested all standard plans that offer the first two PCP and two MH/SUD at a $1 copay visits (all except gold).

The three alternative boundary plan designs used to test the reasonable AV range were as follows:

1. 2025 standard plan designs for each metal, with the same cost sharing applied to all PCP and outpatient MH/SUD services. For the expanded bronze plan design, two boundary designs were included:

    (a) a design with the deductible and coinsurance cost sharing applied to all outpatient MH/SUD services; and

(b) a design with $50 copay cost sharing applied to all PCP visits and outpatient MH/SUD services.

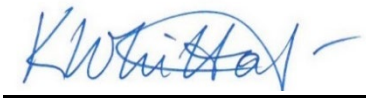
2. 2025 standard plan designs for each metal, with $0 cost-sharing applied to first two PCP visits and all outpatient MH/SUD services. This is a richer boundary case than $1 copay but the AVC does not allow for a $1 copay for initial visits. As such, this provides the closest boundary case within the design of AV calculator.

Wakely modeled each of these plan designs in the final 2025 federal AV calculator. For the expanded bronze plan, the AV for the mixed cost sharing applied to outpatient MH/SUD services (copay for office visits and deductible and coinsurance for all other services) would be a weighted average of the two AVs produced in (1a) and (1b). For all plans above, Acumen's 2025 adjusted AV falls within the AV range produced by the lower and upper boundary plan designs. For the expanded bronze plan, the adjusted actuarial value exceeds both lower bound AVs with different types of cost sharing applied to all MH/SUD outpatient services (copays and deductible / coinsurance). Considering the range of AVs created by these two plans was narrow and considering that the adjusted AV logically fell within this range, Wakely deemed the adjusted AVs calculated by Acumen to be reasonable and actuarially sound.

For silver CSR 73% variation, since the lower bound of silver CSR 73% variation AV fell below the de minimis range minimum at 72.61%, Wakely tested an alternative design by calculating a blended best estimate PCP and MH/SUD copay using an alternative assumption for the portion of MH/SUD annual utilization for the first two visits for a member in a given year. Using these assumptions, a revised blended cost sharing for PCP and MH/SUD, yielding an actuarial value of 73.02%, which represents our best estimate actuarial value for this plan and is above the 73.00% threshold.

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: Ksenia Whittal, FSA, MAAA

Date: April 15, 2024

Appendix C - Acumen's Actuarial Value Calculator Modification Methodology Memorandum

(Begins on next page)

MEMORANDUM

ACUMEN
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TO: Christine Gibert, Kristin Villas, WAHBE
FROM: Acumen, LLC
DATE: April 10, 2024
SUBJECT: Actuarial Value Calculator Modification Methodology

Acumen utilized a modified Final 2025 Actuarial Value Calculator (AVC) to estimate the actuarial value (AV) of proposed 2025 standard plan designs, some of which feature special cost sharing for office visits for primary care and mental health/substance use disorder (MHSUD). The plan designs in question allow enrollees to have up to two office visits of each type (primary care and MHSUD) with a $1 copay before the enrollee is responsible for a higher copay. While the standard AVC supports plan designs with a specified number of upfront no-copay visits for primary care, it does not support this feature for MHSUD office visits and it does not support $1 visits followed by a different copay. By utilizing the built-in upfront cost-sharing option for primary care as a starting point, Acumen modified the AVC to account for both types of office visits and for differential copays to calculate the AV of this plan design. In a separate workbook titled *"2025Designs_Screenshots_Final_2025AVC.xlsx"*, Acumen has included the screenshots of all standard plans for all metal levels to show how these plans are entered in the modified Final 2025 AVC and the original Final 2025 AVC.

Modifications for Office Visit Cost-Sharing

There were three steps in the primary care and MHSUD AVC modification that Acumen performed, following the same methodology utilized to make relevant adjustments to the Final 2024 AVC. First, in each medical and combined continuance table in the AVC, Acumen estimated the proportion of utilization and spending in the MHSUD professional and facility category that was accounted for by office visits, then combined these office visits with the primary care office visits fields. Acumen then allocated this combined field among the "Primary Care > N Visits" fields to create "Primary Care > N Visits & MHSUD > N Visits" fields. Finally, Acumen modified the algorithm underlying the "Begin Primary Care Cost-Sharing After a Set Number of Visits?" special cost sharing option to instead use $1 copays for the inputted number of visits, rather than having the visits be no-cost to the enrollee. Thus, by modifying the underlying fields and algorithm, Acumen leveraged the existing special cost-sharing feature in the AVC to calculate the AV of the plan design. The remainder of this section provides more details on each of these steps.

The MHSUD columns in each medical and combined continuance table in the AVC describe the frequency and cost of outpatient professional and facility services related to MHSUD. Office visits are just one component of these fields, so Acumen had to first estimate

the proportion of these MHSUD columns that were made up of office visits. To do this, Acumen utilized the EDGE 2019 Limited Dataset (EDGE LDS)[1], which is a claims database reflecting the individual and small group markets nationwide, available for purchase on the CMS website.

Using categorization logic similar to that used in the construction of the continuance tables underlying the AVC, Acumen first identified MHSUD-related claims in the EDGE LDS using a combination of revenue codes, place of service, HCPCs, and diagnoses appearing on the claim. Acumen then further identified the office visit claims among these by using both BETOS and Restructured BETOS Classification System (RBCS) codes. Finally, Acumen reweighted the data using the AVC standard population and calculated the proportion of MHSUD outpatient professional and facility claims that consisted of office visits. Proportions were calculated for utilization as well as costs and can be viewed in Table 1 below. These derived proportions were then applied to the "Mental Health – OP Facility", "Avg. Mental Health – OP Facility Freq.", "Mental Health – OP Prof", and "Avg. Mental Health – OP Prof Freq." columns in the AVC medical and combined continuance tables to estimate MHSUD office visit cost and frequency. Once these values were calculated, they were subtracted from the existing MHSUD columns and added to the existing "Primary Care" and "Avg. Primary Care Freq" columns in the continuance table to create modified versions of these columns.

Table 1: Percentage of MHSUD utilization and cost AVC categories calculated to involve office visits

Category	Percentage of Category Considered Office Visit
MHSUD Outpatient Professional Utilization	78.55%
MHSUD Outpatient Facility Utilization	12.65%
MHSUD Outpatient Professional Allowed Cost	80.98%
MHSUD Outpatient Facility Allowed Cost	7.60%

Next, all "Primary Care > N Visits" and "Primary Care > N Visits Freq." columns were modified. These fields are specifically used by the AVC when an AVC user engages the "Begin Primary Care Cost-Sharing After a Set Number of Visits?" special cost-sharing option. This was done by calculating the ratio of these columns to the original values of the "Primary Care" and "Avg. Primary Care Freq." columns, respectively, then multiplying this ratio by the modified versions of the "Primary Care" and "Avg. Primary Care Freq." columns calculated in the previous paragraph. The main assumption is that the additional office visits from MHSUD follow a pattern similar to Primary Care visits. This calculation was done separately for all rows of each medical and combined continuance table. See Figure 1 below for an example of the

[1] Although the 2020 LDS data was the most recent EDGE LDS dataset available at the time the draft 2025 AV Calculator was released, Acumen preferred the 2019 LDS data over the 2020 data due to the expectation that it would be more representative of the future market because the 2020 data was impacted by the COVID-19 pandemic.

calculations for the combined office visit cost field and the "> 1 Visit" cost field for a single row of the silver combined continuance table from the Final 2025 AVC.

Figure 1: Example Calculations for Allowed Costs for $10,000 Row of Silver Combined Continuance Table (Final 2025 AVC)

Up To	Primary Care	Primary Care >1 Visit
	Col (1)	Col (2)
$10,000	$148.93	$88.33

= Col (2) / Col (1)

1-Visit Factor: 59.3%

Up To	Mental Health - OP Facility	Mental Health - OP Prof.
$10,000	$2.82	$154.43

Office Visit Factors:	7.60%	80.98%	*Factors from Table 1*
Office Visit Share of Cost:	$0.21	$125.06	

Total MHSUD Office Visit Cost: $125.27

Final Calculations:

Up To	Primary Care	MHSUD Office Visits	Combined Office Visits	1-Visit Factor	Combined >1 Visit
	Col (1)	Col (2)	Col (3) = Col (1) + Col (2)	Col (4)	= Col (3) * Col (4)
$10,000	$148.93	$125.27	$274.20	59.3%	$162.63

Once the modified versions of all these columns were calculated, Acumen replaced the original columns in the AVC with these new versions. This resulted in the primary care-related AVC special cost-sharing feature thereby being applied to the combined primary care and MHSUD office visit columns. Because the costs added to primary care were removed from the MHSUD-related columns, total cost and utilization—overall and within each row of the continuance tables—did not change. Additionally, a key feature of the Washington standard plan designs is that primary care and MHSUD cost-sharing for office visits is always the same, so no information is lost by combining these categories together.

Finally, the "Begin Primary Care Cost-Sharing After a Set Number of Visits?" special cost sharing feature was modified to instead use $1 copays that are not subject to the deductible for the set number of visits. This feature currently works by utilizing a $0 copay for the first few visits. By simply swapping this $0 copay for a $1 copay, Acumen was able to modify the algorithm to account for this bespoke plan feature.

Appendix D - WAHBE 2025 Standard Plan Designs

(Begins on next page)

WAHBE 2025 Standard Plan Designs

Individual Market Gold, Silver, and Bronze Plans

Benefits	2025 Standard Gold	2025 Standard Silver	2025 Standard Bronze
Deductible and Out-of-Pocket Maximum			
Medical/Pharmacy Integrated Deductible	Yes	Yes	Yes
Medical (or Integrated, if Applicable)/Pharmacy Deductibles ($)	$600	$2,500	$6,000
Medical/Pharmacy Integrated MOOP	Yes	Yes	Yes
Medical/Pharmacy Integrated MOOP ($)	$7,000	$9,200	$9,200
Office Visits			
Preventive Care/Screening/Immunization	$0	$0	$0
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	$15	$30***	$50***
Specialist Visit	$40	$65	$100
Mental/Behavioral Health and Substance Use Disorder Outpatient Services-Office	$15	$30***	$50***
Emergency/Urgent Care Services			
Emergency Care Services	$450	$800	40%
Urgent Care	$35	$65	$100
Ambulance	$375	$375	40%
Outpatient Services			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$350	$600	40%
Outpatient Surgery Physician/Surgical Services	$75	$200	40%
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other	$15	$30	40%
Outpatient Diagnostic Tests			
Laboratory Outpatient and Professional Services	$20	$40	40%
X-rays and Diagnostic Imaging	$30	$65	40%
Advanced Imaging (CT/PET Scans, MRIs)	$300	30%	40%
Inpatient Services			
All Inpatient Hospital Services (inc. MH/SUD, Maternity)	$525*	$800*	40%
Skilled Nursing Facility	$350**	$800**	40%
Pharmacy			
Generics	$10	$25	$32
Preferred Brand Drugs	$60	$75	40%
Non-Preferred Brand Drugs	$100	$250	40%
Specialty Drugs (i.e. high-cost)	$100	$250	40%
All Other Benefits			
Speech Therapy	$25	$40	40%
Occupational and Physical Therapy	$25	$40	40%
Durable Medical Equipment (DME)	20%	30%	40%
Home Health	$15**	$30**	$50**
Hospice	$15**	$30**	$50**
All Other Benefits	20%	30%	40%
Final 2025 AV	81.39%	70.75%	63.64%

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 plans except the Gold standard plan, final 2025 AV is based on a modified version of the federal Final 2025 AV Calculator that accounts for unique plan features. Gold standard plan AV is provided directly by the Final 2025 AV Calculator.

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Individual Market Silver Plan and CSR Variations

Benefits	2025 Standard Silver 94% AV	2025 Standard Silver 87% AV	2025 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	$750	$2,500
Medical/Pharmacy Integrated MOOP	Yes	Yes	Yes
Medical/Pharmacy Integrated MOOP ($)	$1,900	$2,500	$7,250
Office Visits			
Preventive Care/Screening/Immunization	$0	$0	$0
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	$5***	$10***	$30***
Specialist Visit	$15	$30	$65
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Office	$5***	$10***	$30***
Emergency/Urgent Care Services			
Emergency Care Services	$150	$425	$800
Urgent Care	$15	$30	$65
Ambulance	$75	$175	$325
Outpatient Services			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$100	$325	$600
Outpatient Surgery Physician/Surgical Services	$25	$120	$200
Mental/Behavioral Health and Substance Use Disorder Outpatient Services - Other	$5	$10	$30
Outpatient Diagnostic Tests			
Laboratory Outpatient and Professional Services	$5	$20	$40
X-rays and Diagnostic Imaging	$15	$40	$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	$12	$24
Preferred Brand Drugs	$12	$35	$75
Non-Preferred Brand Drugs	$35	$160	$250
Specialty Drugs (i.e. high-cost)	$35	$160	$250
All Other Benefits			
Speech Therapy	$5	$20	$40
Occupational and Physical Therapy	$5	$20	$40
Durable Medical Equipment (DME)	15%	20%	30%
Home Health	$5**	$10**	$30**
Hospice	$5**	$10**	$30**
All Other Benefits	15%	20%	30%
Final 2025 AV	94.73%	87.89%	73.28%

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 plans except the Gold standard plan, final 2025 AV is based on a modified version of the federal Final 2025 AV Calculator that accounts for unique plan features. Gold standard plan AV is provided directly by the Final 2025 AV Calculator.

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2025 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 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
    i. 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 (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.
17. While these 2025 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.

Appendix E – WAHBE 2025 Standard Plans AVC Screenshots (Unadjusted and Adjusted)

(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	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$600.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
MOOP ($)			$7,000.00			
MOOP if Separate ($)						

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:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2025_1a

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	81.39%
Metal Tier:	Gold
	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:	0.0625 seconds

Final 2025 AV Calculator

Wakely
An HMA Company

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:		1st Tier Utilization:	
		2nd Tier Utilization:	

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	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
MOOP ($)			$9,200.00			
MOOP if Separate ($)						

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)	☐	☐		$30.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$65.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$30.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$40.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$40.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$40.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$65.00	☑	☑			☐	☐
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	☐	☐		$25.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
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):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2025_1a

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.39%
Metal Tier:	Silver
	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:	0.082 seconds

Final 2025 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	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

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	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
MOOP ($)			$7,250.00			
MOOP if Separate ($)						

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	☑	☐		$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)	☐	☐		$30.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$65.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$30.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$40.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$40.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$40.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$65.00	☑	☑			☐	☐
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	☐	☐		$24.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
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):		2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2025_1a

Output

Calculate

Status/Error Messages:	Error: Result is outside of [0, +1] percent de minimis variation for CSRs.
Actuarial Value:	72.94%
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:	0.0625 seconds

Final 2025 AV Calculator

Wakely
An HMA Company

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:		1st Tier Utilization: 2nd Tier Utilization:	

ACUMEN

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
MOOP ($)			$2,500.00
MOOP if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

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)	☑	☑			☑	☑			☐	☐
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):		2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2025_1a

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.83%
Metal Tier:	Gold
	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:	0.0703 seconds

Final 2025 AV Calculator

Individual Market Standard Silver, CSR 94% Plan

Wakely
An HMA Company

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:		1st Tier Utilization: 2nd Tier Utilization:	

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$0.00			
Coinsurance (%, Insurer's Cost Share)			85.00%			
MOOP ($)			$1,900.00			
MOOP if Separate ($)						

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)	☐	☐		$5.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$15.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$5.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☑			☑	☑			☐	☐
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	☐	☐		$5.00	☑	☑			☐	☐
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):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2025_1a

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.69%
Metal Tier:	Platinum
	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:	0.0703 seconds

Final 2025 AV Calculator

Wakely
An HMA Company

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:		1st Tier Utilization:	
		2nd Tier Utilization:	

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
MOOP ($)			$9,200.00			
MOOP if Separate ($)						

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	☑	☑			☑	☑			☐	☐
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	☑	☑			☑	☑			☐	☐
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	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

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):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2025_1a

Output

Calculate

Status/Error Messages:	Expanded Bronze Standard (58% to 65%), Calculation Successful.
Actuarial Value:	62.42%
Metal Tier:	Bronze
	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Additional Notes:	
Calculation Time:	0.0938 seconds

Final 2025 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver Plan (Adjusted)

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	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

ACUMEN

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			70.00%
MOOP ($)			$9,200.00
MOOP if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			
Coinsurance (%, Insurer's Cost Share)			
MOOP ($)			
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 & MHSUD Office Visits	☐	☐		$30.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$65.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services other than Office Visits	☐	☐		$30.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$40.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$40.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$40.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$65.00	☑	☑			☐	☐
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	☐	☐		$25.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
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 & MHSUD Office Visit Cost-Sharing After a Set Number of $1 Visits?	☑
# Visits (1-10):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2025_1a

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.75%
Metal Tier:	Silver
	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:	0.0625 seconds

Final 2025 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver, CSR 73% Plan (Adjusted)

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	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

ACUMEN

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			70.00%
MOOP ($)			$7,250.00
MOOP if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

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 & MHSUD Office Visits	☐	☐		$30.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$65.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services other than Office Visits	☐	☐		$30.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☐	☐		$40.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$40.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☐		$40.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☐		$65.00	☑	☑			☐	☐
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	☐	☐		$24.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
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 & MHSUD Office Visit Cost-Sharing After a Set Number of $1 Visits?	☑
# Visits (1-10):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2025_1a

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.28%
Metal Tier:	Silver
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:	0.0781 seconds

Final 2025 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver, CSR 87% Plan (Adjusted)

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:		1st Tier Utilization:	
		2nd Tier Utilization:	

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$750.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
MOOP ($)			$2,500.00			
MOOP if Separate ($)						

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	☑	☐		$425.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☐		$425.00	☑	☑			☑	☐
Primary Care & MHSUD Office Visits	☐	☐		$10.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$30.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services other than Office Visits	☐	☐		$10.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
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 & MHSUD Office Visit Cost-Sharing After a Set Number of $1 Visits?	☑
# Visits (1-10):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2025_1a

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.89%
Metal Tier:	Gold
	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:	0.0586 seconds

Final 2025 AV Calculator

Wakely
An HMA Company

Individual Market Standard Silver, CSR 94% Plan (Adjusted)

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:		1st Tier Utilization: 2nd Tier Utilization:	

ACUMEN

Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design			
	Medical	Drug	Combined		Medical	Drug	Combined
Deductible ($)			$0.00				
Coinsurance (%, Insurer's Cost Share)			85.00%				
MOOP ($)			$1,900.00				
MOOP if Separate ($)							

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	☐	☐		$150.00	☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☐	☐		$100.00	☑	☑			☐	☐
Primary Care & MHSUD Office Visits	☐	☐		$5.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$15.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services other than Office Visits	☐	☐		$5.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☑			☑	☑			☐	☐
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	☐	☐		$5.00	☑	☑			☐	☐
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 & MHSUD Office Visit Cost-Sharing After a Set Number of $1 Visits?	☑	
# Visits (1-10):		2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2025_1a

Output

Calculate

Status/Error Messages: CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value: 94.73%
Metal Tier: Platinum
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: 0.0625 seconds
Final 2025 AV Calculator

Wakely
An HMA Company

Individual Market Standard Bronze Plan (Adjusted)

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:		1st Tier Utilization:	
		2nd Tier Utilization:	

ACUMEN

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
MOOP ($)			$9,200.00			
MOOP if Separate ($)						

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	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care & MHSUD Office Visits	☐	☐		$50.00	☑	☑			☐	☐
Specialist Visit	☑	☐		$100.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services other than Office Visits	☑	☑			☑	☑			☐	☐
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	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

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 & MHSUD Office Visit Cost-Sharing After a Set Number of $1 Visits?	☑
# Visits (1-10):	2
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2025_1a

Output

Calculate

Status/Error Messages:	Expanded Bronze Standard (58% to 65%), Calculation Successful.
Actuarial Value:	63.64%
Metal Tier:	Bronze
	NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.
Additional Notes:	
Calculation Time:	0.0625 seconds

Final 2025 AV Calculator