Wakely
An HMA Company

May 6, 2022

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

RE: Actuarial Value Certification for WAHBE 2023 Standard Medical Plan Designs

Dear Christine:

This memo is an update to the 2023 AV certification memo for the 2023 standardized plans provided on April 6, 2022. The only changes are to confirm the finalization of the 2023 Notice of Benefit and Payment Parameters (NBPP)[1] and Actuarial Value Calculator (AVC). All proposed changes related to standard plan designs (e.g., AVC, de minimis ranges for actuarial values) were finalized as proposed. Thus, no changes to the standard plan designs are needed based on the final NBPP or AVC.

For the 2023 standardized plans, benefit changes were made to account for the updates made to the 2023 Federal AV calculator. Those changes within the 2023 calculator included updating the underlying data from 2017 to 2018, and applying trend to project medical and pharmacy expenses in 2023. These updates had varying impacts by metal level with the largest impact being on silver metal level plans. Therefore, plan designs listed below reflect the necessary updates made to the plan designs in order for the plans to remain compliant per the 2023 Federal AV calculator. Further detail around the Federal AV Calculator is found in the following paragraphs and sections.

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 (AVs) 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 2023 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. The 2023 NBPP finalized 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. Note that these ranges are smaller than prior years, which had a low end at -4% (no change to the high end of the range). The plan designs presented here comply with this proposed AV range. Bronze plan

[1] https://www.cms.gov/files/document/cms-9911-f-patient-protection-final-rule.pdf

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 Bronze standard plan qualifies for the expanded range. 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 2023 NBPP allows for a 0%/+1% de minimis range around the target AVs for CSR plans (e.g., 73% to 74% AV for a 73% CSR plan).

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 2023, 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, an HMA Company (Wakely) to assist with the development of 2023 standard plan designs and validation of the federal AVs for the 2023 standard plan designs. Compliance of the benefit designs in relation to other regulatory benefit design constraints has not been evaluated by Wakely.

A summary of WAHBE's standard plan designs is in Appendix C. Most of the cost sharing features of 2023 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 Office of the Insurance Commissioner (OIC) has confirmed with the Center for Consumer Information and Insurance Oversight (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.

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

In addition, the Bronze standard plan design specifies that outpatient Mental Health/Substance Use Disorder (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 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, includes the update from the 2022 plan appendix that notes 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 2023 is in Appendix C. Wakely utilized the 2023 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.[3]

Wakely 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

[3] The screen shots are from the draft AVC. Since no changes were made from the draft to final AVC, the screen shots have not been updated.

data for nationwide individual ACA claims experience in 2018. Wakely's ACA claims experience consists of 3.8 million lives and $19.0 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 2017 to 2018.

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. Wakely 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 2018 to 2023. The average claims cost used in the calibration were derived from the carrier's filed 2022 URRTs, and then trended to 2023 using the trend found within the Federal AVC calculator. The adjustment was done based on high level category of service for inpatient, outpatient, professional, pharmacy, and other services.
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. Wakely 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	82.61%	81.88%	0.9912
Standard Silver	71.96%	71.53%	0.9940
Standard Silver, 73% AV CSR Variation	73.97%	73.55%	0.9943
Standard Silver, 87% AV CSR Variation	88.17%	87.79%	0.9956
Standard Silver, 94% AV CSR Variation	94.48%	94.48%	1.0000
Standard Bronze	64.34%	64.21%	0.9981

Disclosures and Limitations

Responsible Actuary. Brad Heywood is the actuary responsible for this communication. Brad is a member of the American Academy of Actuaries and an Associate of the Society of Actuaries. Brad meets the Qualification Standards of the American Academy of Actuaries to issue this report. Brittney Phillips, ASA, MAAA, also contributed significantly to 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 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.

Data and Reliance. Wakely relied on information supplied by WAHBE in this assignment. Wakely has reviewed the data 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 2023 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.

Subsequent Events. There are no known subsequent events to the date of this report that could impact the plan designs presented.

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,

Brad Heywood, ASA, MAAA
Consulting Actuary
720-221-9601

Appendix A

Adjusted Actuarial Value Certification

Washington Health Benefit Exchange Standard Plan Designs Effective January 1, 2023

I, Brad Heywood, is associated with the firm of Wakely Consulting Group, LLC, an HMA Company (Wakely), is 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, 2023. 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 2023 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 2023 WAHBE standard plan designs with unique designs that could not be accommodated by the AV Calculator that will be effective as of January 1, 2023 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.

Brad Heywood, ASA, MAAA

Consulting Actuary,
Wakely Consulting Group, LLC, an HMA Company
May 6, 2022

Appendix B

Actuarial Value Certification

Unique Plan Design Supporting Documentation and Justification

Applicable Plans: 2023 Standard Gold, Standard Silver, the Silver 73% CSR, the Silver 87% CSR, the Silver 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.

Wakely has 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 2018.

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: Wakely utilized a proprietary data set reflecting nationwide ACA individual market experience from 2018, trended to 2023 by calibrating to 2022 Washington filed URRT's and then trended assuming the appropriate trends underlying the Federal AV Calculator, 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), Wakely 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. Wakely 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, Wakely 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. Wakely 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: Brad Heywood, ASA, MAAA

Date: May 6, 2022

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

Appendix C

WAHBE 2023 Standard Plan Designs
Individual Market Gold, Silver, and Bronze Plans

Benefits	Standard Gold	Standard Silver	Standard Bronze
Deductible and Out-of-Pocket Maximum			
Medical/Pharmacy Integrated Deductible	No	Yes	Yes
Medical (or Integrated, if Applicable)/Pharmacy Deductibles ($)	$600 / $0	$2,500	$6,000
Medical/Pharmacy Integrated MOOP	Yes	Yes	Yes
Medical/Pharmacy Integrated MOOP ($)	$5,900	$8,500	$8,550
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%
Federal AV Unadjusted	**82.61%**	**71.96%**	**64.34%**
AV Factor Adjustment	0.9912	0.9940	0.9981
Federal AV Adjusted	**81.88% *** **	**71.53% *** **	**64.21% *** **

Shaded items are not subject to the deductible.
* Per day copay, limit of 5 copays per stay;
** Per day copay;
*** Federal 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 Standard Silver Plan CSR Variations

Benefits	Standard Silver 94% AV	Standard Silver 87% AV	Standard Silver 73% AV
Deductible and Out-of-Pocket Maximum			
Medical/Pharmacy Integrated Deductible	Yes	No	Yes
Medical (or Integrated, if Applicable)/Pharmacy Deductibles ($)	$0	$750 / $0	$2,500
Medical/Pharmacy Integrated MOOP	Yes	Yes	Yes
Medical/Pharmacy Integrated MOOP ($)	$1,200	$2,400	$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	$20
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%
Federal AV Unadjusted	**94.48%**	**88.17%**	**73.97%**
AV Factor Adjustment	1.0000	0.9956	0.9943
Federal AV Adjusted	**94.48% *** **	**87.79% *** **	**73.55% *** **

Shaded items are not subject to the deductible.
* Per day copay, limit of 5 copays per stay;
** Per day copay;
*** Federal 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.

2023 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
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 2023 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 ($)	$600.00	$0.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	80.00%				
MOOP ($)	$5,900.00					
MOOP if Separate ($)						

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	☑	☐		$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	☐	☐	$1.00	$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: 2023_1e

Output

Calculate

Status/Error Messages: Error: Result is outside of [-2, +2] percent de minimis variation.
Actuarial Value: 82.61%
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: 0.1094 seconds

Draft 2023 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 ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
MOOP ($)			$8,500.00			
MOOP if Separate ($)						

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	☑	☐		$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)	☑	☑		$0.00	☐	☐			☐	☐
Speech Therapy	☐	☐		$40.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$40.00	☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	$1.00	$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):		
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: 2023_1e

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.96%
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:	0.0781 seconds

Draft 2023 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 ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
MOOP ($)			$7,250.00			
MOOP if Separate ($)						

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)	☑	☑		$0.00	☐	☐			☐	☐
Speech Therapy	☐	☐		$40.00	☐	☐			☐	☐
Occupational and Physical Therapy	☐	☐		$40.00	☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	$1.00	$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	☐	☐		$20.00	☐	☐			☐	☐
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):		
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Plan Description:

Name: Standard Silver 73%
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2023_1e

Output

Calculate

Status/Error Messages: CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value: 73.97%
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: 0.0703 seconds
Draft 2023 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	$0.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	80.00%				
MOOP ($)	$2,400.00					
MOOP if Separate ($)						

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 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	☐	☐	$1.00	$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%

Plan HIOS ID:

Issuer HIOS ID:

AVC Version: 2023_1e

Output

Calculate

Status/Error Messages: Error: Result is outside of [0, +1] percent de minimis variation for CSRs.

Actuarial Value: 88.17%

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: 0.1094 seconds

Draft 2023 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 ($)			$0.00			
Coinsurance (%, Insurer's Cost Share)			85.00%			
MOOP ($)			$1,200.00			
MOOP if Separate ($)						

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	☐	☐		$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	☐	☐	$1.00	$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):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: Standard Silver 94%
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2023_1e

Output

Calculate

Status/Error Messages: CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value: 94.48%
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: 0.0508 seconds
Draft 2023 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

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	☐	☐		$50.00	☐	☐			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☐	☐			☐	☐
Speech Therapy	☑	☑			☐	☐			☐	☐
Occupational and Physical Therapy	☑	☑			☐	☐			☐	☐
Preventive Care/Screening/Immunization	☐	☐	$1.00	$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: 2023_1e

Output

Calculate

Status/Error Messages: Expanded Bronze Standard (58% to 65%), Calculation Successful.
Actuarial Value: 64.34%
Metal Tier: Bronze
NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Additional Notes:

Calculation Time: 0.0781 seconds
Draft 2023 AV Calculator