User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution?	? □		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			t Tier Utilization:				
Use Separate OOP Maximum for Medical and Drug Spending?	_				2nd	l Tier Utilization:	ļ,			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	The state of the s									
Desired Metal Tier		r 1 Plan Benefit De		1	T:	2 Plan Benefit I	D!			
	Medical	Drug	Combined	-	Medical	Drug	Combined			
Deductible (\$)	\$0.00	\$0.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)	\$2,00									
MOOP if Separate (\$)				-						
Click Here for Important Instructions		Tie	er 1			Ti	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Conav annlies only	after deductible?
<u> </u>	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	All			✓ All	✓ All			□All	L All
Emergency Room Services				\$100.00	✓	✓				
All Inpatient Hospital Services (inc. MHSU)				\$500.00	✓	✓				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00	✓	✓			l 🗆	
Specialist Visit				\$35.00	✓	✓				
		<del></del>							_	
Mental/Behavioral Health and Substance Use Disorder Outpatient Services				\$15.00	✓	✓				
Imaging (CT/PET Scans, MRIs)				\$35.00	✓	✓				
Speech Therapy				\$25.00	<b>▽</b>	✓				
				\$25.00	✓	✓				
Occupational and Physical Therapy								1	_	
Preventive Care/Screening/Immunization			100%	\$0.00	✓	✓	100%	\$0.00		
Laboratory Outpatient and Professional Services				\$35.00	✓ ✓	✓				
X-rays and Diagnostic Imaging Skilled Nursing Facility				\$35.00 \$500.00	✓	<u> </u>				-
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				\$100.00	✓	✓				
Outpatient Surgery Physician/Surgical Services				\$100.00	<b>✓</b>	<b>√</b>				
Drugs	☐ All	All			✓ All	✓ All			☐ All	All
Generics				\$10.00	<b>✓</b>	✓				
Preferred Brand Drugs				\$30.00	<b>V</b>	✓				
Non-Preferred Brand Drugs				\$60.00	✓	✓				
Specialty Drugs (i.e. high-cost)				\$60.00	<b>✓</b>	<b>√</b>				
Options for Additional Benefit Design Limits:		Ī	Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	[Input Plan Name						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	[Input Plan HIOS						
Set a Maximum Number of Days for Charging an IP Copay?	Ц		Issuer HIOS ID:	[Input Issuer HIO:	S IDJ					
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?	ш									
# Visits (1-10): Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
•										
Status/Error Messages:	Calculation Success	sful.								
Actuarial Value:	87.23%									
Metal Tier:	Platinum									
	NOTE: Service-spec	cific cost-sharing is	applying for service	e(s) with fac/prof	components, ov	erriding outpation	ent inputs for those	service(s).		
Additional Notes:										
Calculation Time:	0.2227 seconds									
Pavisad 2018 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	e? HSA/HRA Options			Ti	ered Network Op	tion				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🔲	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?	· 🗆		bution Amount:		1s	t Tier Utilization:				
Use Separate OOP Maximum for Medical and Drug Spending?	· 🗆	Allitual Colletti	bution Amount.		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?					-					
Desired Metal Tier	Gold ▼			_						
	Tie	r 1 Plan Benefit De	esign		Tie	r 2 Plan Benefit D	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$600.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)	\$4,0	00.00								
MOOP if Separate (\$)										
									1	<b>-</b> : •
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		<b>∏</b> All
Medical	<b>⊘</b> All			6450.00					<b>→</b>	
Emergency Room Services				\$150.00		<b></b> ✓				
All Inpatient Hospital Services (inc. MHSU)	✓			\$1,000.00	✓	✓			7	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	7			\$25.00	✓	✓			₹.	
Specialist Visit	7	is.		\$40.00	✓	V			7	
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	7			\$25.00	V	V			☑	
Imaging (CT/PET Scans, MRIs)	<b>√</b>			\$40.00	<b>V</b>	<b></b> ✓			7	
Speech Therapy	J			\$30.00	<b>✓</b>				7	
эресси тистиру										
Occupational and Physical Therapy	✓			\$30.00	✓	☑			7	
Preventive Care/Screening/Immunization			100%	\$0.00			100%	\$0.00		
Laboratory Outpatient and Professional Services	✓		10070	\$40.00		<u> </u>	10070	Ş0.00	7	
X-rays and Diagnostic Imaging	✓			\$40.00	<b></b> ✓	2			2	
Skilled Nursing Facility	<b>√</b>			\$1,000.00	<b>2</b>	2			2	
Skilled Nulsing Facility				\$1,000.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	7			\$100.00	✓	V			7	
Outpatient Surgery Physician/Surgical Services	✓			\$100.00	<b>√</b>	V			7	
Drugs	<b>□</b> All	<b>∏</b> All			ZAH	ZAII			<b>□</b> All	Aii
Generics			_	\$10.00	✓	√.				
Preferred Brand Drugs				\$35.00	✓	✓				
Non-Preferred Brand Drugs				\$70.00	✓	✓				
Specialty Drugs (i.e. high-cost)				\$70.00	✓	✓				
Options for Additional Benefit Design Limits:	-		Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?	· 🔲	]	Name:	[Input Plan Name	]					
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	[Input Plan HIOS I						
Set a Maximum Number of Days for Charging an IP Copay?	· 🔲		Issuer HIOS ID:	[Input Issuer HIOS	S ID]					
# 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):										
Output		1								
Status/Error Messages:	Calculation Succes	sful.								
Actuarial Value:	78.62%									
Metal Tier:	Gold									
	NOTE: Service-spec	cific cost-sharing is	applying for servic	e(s) with fac/prof co	omponents, ove	rriding outpatien	t inputs for those s	service(s).		
Additional Notes:										
Calculation Time:	0.1367 seconds									
Revised 2018 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?						ered Network O <sub>l</sub>				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			t Tier Utilization:				
Use Separate OOP Maximum for Medical and Drug Spending?	_				2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier										
		r 1 Plan Benefit De	esign		Tie	r 2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)		50.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	or 1			Ti	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible?
Medical	-ZAUI	<b>∏</b> AII			-ZAII	[√Ali			-√AII	∏ <b>A</b> II
Emergency Room Services	<b>₹</b>			\$250.00	✓	<b>✓</b>			V	
All Inpatient Hospital Services (inc. MHSU)	✓			\$1,500.00	<b>V</b>	✓			✓	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	✓			\$30.00	✓	✓			7	
Specialist Visit	~			\$50.00	<b></b> ✓	✓			2	
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	Į.			\$30.00		<b>2</b>			J	
					■	<b>∠</b>				
Imaging (CT/PET Scans, MRIs)	7			\$50.00 \$30.00	✓ ✓	✓ ✓			7	
Speech Therapy										
Occupational and Physical Therapy	✓			\$30.00	✓	✓			7	
Preventive Care/Screening/Immunization			100%	\$0.00			100%	\$0.00		
Laboratory Outpatient and Professional Services	<b>₹</b>			\$50.00	✓	✓			<b>√</b>	
X-rays and Diagnostic Imaging	<b>√</b>			\$50.00	✓	✓			✓	
Skilled Nursing Facility	✓			\$1,500.00	✓	✓			V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓			\$100.00	<b></b> ✓	<b>✓</b>			Ø.	
Outpatient Surgery Physician/Surgical Services	<b>√</b>			\$100.00	V	V			<b>√</b>	
Drugs	<b>□</b> Au	All		7 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 -	-ZAII	ZAII			<b>A</b> II	<b>□</b> AII
Generics				\$10.00	<b>₹</b>	<b></b> ✓				
Preferred Brand Drugs				\$35.00	<b>✓</b>	<b>√</b>				
Non-Preferred Brand Drugs				\$70.00	<b></b> ✓	✓				
Specialty Drugs (i.e. high-cost)				\$70.00	7	V				
Options for Additional Benefit Design Limits:	_	1	Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	[Input Plan Name						
Specialty Rx Coinsurance Maximum: Set a Maximum Number of Days for Charging an IP Copay?			Plan HIOS ID: Issuer HIOS ID:	[Input Plan HIOS I [Input Issuer HIOS	-					
# Days (1-10):			issuel IIIOS ID.	[III]put issuer filos	ן טו כ					
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):	:									
Output										
Status/Error Messages:	Calculation Success	sful.								
Actuarial Value:	70.30%									
Metal Tier:	Silver									
		cific cost-sharing is	applying for servic	e(s) with fac/prof co	omponents, ove	rriding outpatier	nt inputs for those s	service(s).		
Additional Notes:										
Calculation Time:	0.1094 seconds									
Revised 2018 AV Calculator	0.1094 Seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?					Ti	ered Network Op	otion			
Apply Inpatient Copay per Day?					Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	bution Amount:		19	t Tier Utilization:				
Use Separate OOP Maximum for Medical and Drug Spending?		Annual Contri	oution Amount.		2n	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?		='			-		-			
Desired Metal Tier				_						
		r 1 Plan Benefit De				r 2 Plan Benefit D				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,650.00	\$0.00	\$0.00							
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%	100.00%							
MOOP (\$)		50.00	\$2,000.00							
MOOP if Separate (\$)			1				ı			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible?
Medical	✓ All	All			✓ All	✓ All			✓ All	All
Emergency Room Services	7			\$250.00	✓	V			<b>V</b>	
All Inpatient Hospital Services (inc. MHSU)	<b>✓</b>	Ш		\$1,500.00	✓	✓			✓	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<b>4</b>			\$30.00	<b>4</b>	<b>4</b>			Z	
Specialist Visit	<b>√</b>			\$50.00	✓	<b>√</b>			<b>V</b>	
		_								
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<b>V</b>	$\sqcup$		\$30.00	✓	✓			✓	
Imaging (CT/PET Scans, MRIs)	J			\$50.00	<b>✓</b>	J.			✓	
Speech Therapy	<b>✓</b>			\$30.00	✓	V			<b>V</b>	
	Image: section of the content of the			\$30.00	<b></b> ✓	<b></b> ✓			Z.	
Occupational and Physical Therapy										
Preventive Care/Screening/Immunization			100%	\$0.00			100%	\$0.00		
Laboratory Outpatient and Professional Services				\$50.00	<b>✓</b>	<u> </u>			<b></b>	
X-rays and Diagnostic Imaging				\$50.00	✓	<u> </u>			<b>V</b>	
Skilled Nursing Facility	<u> </u>			\$1,500.00	✓	✓			✓	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<b>4</b>			\$100.00	✓	<b>Z</b>			<b>4</b>	
Outpatient Surgery Physician/Surgical Services	7			\$100.00	✓	✓			7	
Drugs	All	All			✓ All	✓ All			L All	All
Generics				\$10.00	✓	<u> </u>				
Preferred Brand Drugs				\$35.00	✓	<u> </u>				
Non-Preferred Brand Drugs	Ц	<u> </u>		\$70.00	✓	✓				
Specialty Drugs (i.e. high-cost)				\$70.00	<b>✓</b>	✓				
Options for Additional Benefit Design Limits:	1.1	1	Plan Description:		1					
Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	Ш		Name: Plan HIOS ID:	[Input Plan Name [Input Plan HIOS I						
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	[Input Issuer HIOS						
# Days (1-10):			issuei filos ib.	[III]put issuel Tilos	נטו ט					
Begin Primary Care Cost-Sharing After a Set Number of Visits?	Ш									
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output		•								
Status/Error Messages:	CSR Level of 73% (	200-250% FPL), Cal	culation Successful	l.						
Actuarial Value:	72.32%									
Metal Tier:	Silver			/						
	NOTE: Service-spec	citic cost-sharing is	applying for servic	e(s) with fac/prof c	omponents, ove	erriding outpatier	nt inputs for those :	service(s).		
Additional Notes:										
Calculation Time	0.1004									
Calculation Time:	0.1094 seconds									

User Inputs for Plan Parameters												
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Ti	ered Network O	ption					
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	?	Tiere	d Network Plan?	· 🗆					
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1s	t Tier Utilization:						
Use Separate OOP Maximum for Medical and Drug Spending?		Annual Contin	bution Amount.		2nd	d Tier Utilization:						
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?												
Desired Metal Tier		r 1 Plan Benefit De	-1		T:-	r 2 Plan Benefit I	D!					
	Medical	Drug	Combined	_	Medical	Drug	Combined					
Deductible (\$)		\$0.00	Combined		iviedicai	Drug	Combined					
Coinsurance (%, Insurer's Cost Share)		100.00%										
MOOP (\$)		00.00										
MOOP if Separate (\$)												
Click Here for Important Instructions			er 1				ier 2		Tier 1	Tier 2		
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	y after deductible?		
··	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate				
Medical	<b>₩</b>			675.00					<b>ZA</b> II			
Emergency Room Services	<u> </u>			\$75.00	<b>₹</b>	✓			7			
All Inpatient Hospital Services (inc. MHSU)	✓			\$250.00	<u> </u>	✓			₹	Ш		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	✓			\$15.00	✓	✓			7			
Specialist Visit	✓			\$35.00	V	✓			7			
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	7			\$15.00	<b></b> ✓	✓			₽.			
Imaging (CT/PET Scans, MRIs)	7			\$35.00	<b></b> ✓	<b>√</b>			J			
Speech Therapy	J			\$25.00	<b></b> ✓	✓			J			
	V			\$25.00	V	✓			Ø.			
Occupational and Physical Therapy				\$25.00								
Preventive Care/Screening/Immunization			100%	\$0.00			100%	\$0.00				
Laboratory Outpatient and Professional Services	~			\$35.00	✓	✓			7			
X-rays and Diagnostic Imaging	7			\$35.00	V	✓			7			
Skilled Nursing Facility	✓			\$250.00	<b></b> ✓	✓			7			
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V			\$75.00	V	☑			7			
Outpatient Surgery Physician/Surgical Services	7			\$75.00	✓	✓			7			
Drugs	<b>□</b> All	<b>□</b> AII			✓AII	✓AII			<b>□</b> AII	<b>□</b> AII		
Generics	1			\$9.00	✓	✓						
Preferred Brand Drugs				\$20.00	✓	✓						
Non-Preferred Brand Drugs				\$40.00	<b></b> ✓	✓						
Specialty Drugs (i.e. high-cost)				\$40.00	V	✓						
Options for Additional Benefit Design Limits:		,	Plan Description:									
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	[Input Plan Name	•							
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	[Input Plan HIOS								
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	[Input Issuer HIO	S IDJ							
# 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):												
Output												
Status/Error Messages:	CSR Level of 87% (	150-200% EDIA Cal-	culation Successful	İ								
Actuarial Value:	86.09%	130-20070 FPLJ, Call	cuiation successful									
Metal Tier:	Gold											
Weeter Her.		rific cost-sharing is	anniving for service	ce(s) with fac/prof c	omnonents ove	rriding outnaties	nt innuts for those s	ervice(s)				
Additional Notes:	Jei vice-spei	c cost straining is	applying for service	e(s) with fac/piol to	ponents, ove	am <sub>6</sub> outpatiei	pats for those s	.c. vicc(3).				
, additional Hotes.												
Calculation Time:	0.0703 seconds											
Revised 2018 AV Calculator												

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options			ered Network O <sub>l</sub>				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?	_	Annual Contri	bution Amount:			t Tier Utilization:				
Use Separate OOP Maximum for Medical and Drug Spending?	_				2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier										
		r 1 Plan Benefit De	esign		Tie	r 2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$0.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)	. ,	00.00								
MOOP if Separate (\$)							ı			
Click Here for Important Instructions		Tie	er 1			Ti	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible?
Medical	<b>□</b> All	<b>□</b> All			-ZAII	[√Ali			TAII	∏ <b>A</b> II
Emergency Room Services				\$50.00	✓	<b>✓</b>				
All Inpatient Hospital Services (inc. MHSU)				\$100.00	<b>V</b>	<b>V</b>				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$10.00	<b></b> ✓	✓				
Specialist Visit		<b>1</b>		\$20.00	<b></b> ✓	✓				
Mental/Behavioral Health and Substance Use Disorder Outpatient Services				\$10.00		<b>2</b>				
					✓	_			<del>                                     </del>	
Imaging (CT/PET Scans, MRIs)				\$20.00 \$15.00	✓ ✓	✓ ✓				
Speech Therapy										
Occupational and Physical Therapy				\$15.00	✓	✓				
Preventive Care/Screening/Immunization			100%	\$0.00			100%	\$0.00		
Laboratory Outpatient and Professional Services				\$20.00	✓	✓				
X-rays and Diagnostic Imaging				\$20.00	✓	✓				
Skilled Nursing Facility				\$100.00	<b>V</b>	<b>7</b>				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				\$25.00	✓	✓				
Outpatient Surgery Physician/Surgical Services				\$25.00	<b></b> ✓	<b></b> ✓				
Drugs	<b>∏</b> All	All		·	<b>Z</b> AII	<b></b> Z <b>A</b> II			<b>□</b> All	<b>□</b> AII
Generics	4	1	_	\$6.00	V	V				
Preferred Brand Drugs				\$15.00	✓	<b>✓</b>				
Non-Preferred Brand Drugs				\$30.00	<b>V</b>	✓				
Specialty Drugs (i.e. high-cost)				\$30.00	V	V				
Options for Additional Benefit Design Limits:	_	1	Plan Description:		_					
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	[Input Plan Name						
Specialty Rx Coinsurance Maximum: Set a Maximum Number of Days for Charging an IP Copay?		1	Plan HIOS ID: Issuer HIOS ID:	[Input Plan HIOS I [Input Issuer HIOS	-					
# Days (1-10):			issuel filos ib.	[IIIput issuel Tilos	נטו כ					
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):										
Output										
Status/Error Messages:	CSR Level of 94% (	100-150% FPL), Cal	culation Successful							
Actuarial Value:	93.51%	,,								
Metal Tier:	Platinum									
	NOTE: Service-spe	cific cost-sharing is	applying for servic	e(s) with fac/prof co	omponents, ove	rriding outpatier	nt inputs for those s	service(s).		
Additional Notes:										
Calculation Time:	0.0664 seconds									
Revised 2018 AV Calculator	5.000+ Jeconus									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible			HSA/HRA Options		Ti	ered Network Op	otion			
Apply Inpatient Copay per Day		HSA/HRA Emp	oloyer Contribution	? 🔲	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day		Annual Contri	bution Amount:		1s	t Tier Utilization:				
Use Separate OOP Maximum for Medical and Drug Spending		Annual Contin	button Amount.		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard										
Desired Metal Tie				-	_					
	Medical	L Plan Benefit De	Combined	-	Medical	r 2 Plan Benefit D	Combined			
Deductible (\$		Drug	\$4,000.00	-	iviedicai	Drug	Combined			
Coinsurance (%, Insurer's Cost Share			50.00%							
MOOP (\$			\$7,150.00	1						
MOOP if Separate (\$			\$7,130.00	_						
							•			
Click Here for Important Instructions			er 1				er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
<u> </u>	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	- <b>A</b> III	- <b>⊘</b> All								[AII
Emergency Room Services	2	7			<b>✓</b>	<b></b> ✓				
All Inpatient Hospital Services (inc. MHSU)	[4]	4				<u> </u>				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	2	7			✓	✓				
Specialist Visit	7	~			✓	V				
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	7	J			V	V				
Imaging (CT/PET Scans, MRIs)	7	¥			V	<b></b> ✓				
Speech Therapy	V	✓			✓	<b></b> ✓				
	V	<b>√</b>			V	<b>2</b>				
Occupational and Physical Therapy										
Preventive Care/Screening/Immunization			100%	\$0.00			100%	\$0.00		
Laboratory Outpatient and Professional Services	~	~			✓	<b>∠</b>				
X-rays and Diagnostic Imaging	~	~			✓	<b></b> ✓				
Skilled Nursing Facility	✓	✓			✓	<b></b> ✓				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	7			✓	<b></b> ✓				
Outpatient Surgery Physician/Surgical Services	✓	✓			✓	V				
Drugs	<b>ZA</b> II	<b>□</b> AII			<b>Z</b> AII	ZAII			ZAII	<b>□</b> Aii
Generics	✓			\$10.00	✓	V			7	
Preferred Brand Drugs	7			\$35.00	✓	V			7	
Non-Preferred Brand Drugs	~			\$70.00	✓	<b></b> ✓			7	
Specialty Drugs (i.e. high-cost)	V			\$70.00	✓	V			7	
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments			Name:	[Input Plan Name	-					
Specialty Rx Coinsurance Maximum			Plan HIOS ID:	[Input Plan HIOS						
Set a Maximum Number of Days for Charging an IP Copay			Issuer HIOS ID:	[Input Issuer HIO	ן טו					
# 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 o										
Copays'										
# Copays (1-10)										
Output										
Status/Error Messages:	Calculation Successfo	d								
Actuarial Value:	61.44%	л.								
Actuariai value: Metal Tier:	Bronze									
Wetar ner.	DI UIIZE									
Additional Notes:										
Calculation Time:	0.0664 seconds									
Revised 2018 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Ti	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	ed Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			t Tier Utilization:				
Use Separate OOP Maximum for Medical and Drug Spending?		7 ii ii idai Coi ici	bation / unoanti		2n	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4 5 6 5			_	201 0 61				
	Medical	1 Plan Benefit De Drug	Combined		Medical	r 2 Plan Benefit I Drug	Combined			
Deductible (\$)		Drug	\$5,500.00	-	ivieuicai	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)			50.00%							
MOOP (\$)			\$6,550.00	1						
MOOP if Separate (\$)			\$0,550.00	_						
,,			•							
Click Here for Important Instructions			er 1			Ti	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
··	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	ZAII	ZAII				All			TAII	[All
Emergency Room Services	<b>₹</b>	√			✓	✓				
All Inpatient Hospital Services (inc. MHSU)	✓	√			✓	✓				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	✓	✓			V	✓				
Specialist Visit	<b>√</b>	V			✓	✓				
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	✓	J			V	✓				
Imaging (CT/PET Scans, MRIs)	J	7			<b></b> ✓	<b>V</b>				
Speech Therapy	J	J			✓	✓				
	<b>□</b>	✓			<b></b> ✓	✓				
Occupational and Physical Therapy	·	4								
Preventive Care/Screening/Immunization			100%	\$0.00			100%	\$0.00		
Laboratory Outpatient and Professional Services	V	<b>√</b>			✓	✓				
X-rays and Diagnostic Imaging	✓	J			✓	✓				
Skilled Nursing Facility	✓	J			✓	✓				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	J	V			V	✓				
Outpatient Surgery Physician/Surgical Services	V	J			V	✓				
Drugs	-ZAII	<b>□</b> All			✓AII	✓AII			ZAII	Aii
Generics	V			\$10.00	<b>√</b>	<b>√</b>			J	
Preferred Brand Drugs	V			\$35.00	✓	✓			7	
Non-Preferred Brand Drugs	✓			\$70.00	✓	✓			J	
Specialty Drugs (i.e. high-cost)	✓			\$70.00	✓	✓			J	
Options for Additional Benefit Design Limits:			Plan Description:		-				-	
Set a Maximum on Specialty Rx Coinsurance Payments?	· 🗆		Name:	[Input Plan Name	·]					
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	[Input Plan HIOS						
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	[Input Issuer HIO	S ID]					
# 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):										
·										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	60.87%									
Metal Tier:	Bronze									
Additional Notes:										
Calculation Time:	0.0586 seconds									
Revised 2018 AV Calculator										