User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?		☐ HSA/HRA Options					ption			
Apply Inpatient Copay per Day?		HSA/HRA Emplo	yer Contribution	? 🗌	Tiered					
Apply Skilled Nursing Facility Copay per Day?		Annual Cantail	bution Amount:		1st 7	Tier Utilization				
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	bution Amount:		2nd 7	Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Platinum 🔻									
	Tier	1 Plan Benefit De	esign		Tier	2 Plan Benefit	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$0.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$2,0	00.00				•				
MOOP if Separate (\$)				_						
			•			•	•			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applie	s only after
Type of Benefit	Deductible?	Coinsurance?	different	separate		Coinsurance?		separate	deduct	
Medical	□ All	☐ All			✓ All	✓ All			□ All	☐ All
Emergency Room Services				\$100.00	<u> </u>	<u> </u>				
All Inpatient Hospital Services (inc. MH/SUD)				\$500.00		_ _				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and										
X-rays)				\$15.00	✓	✓				
Specialist Visit				\$35.00	✓	✓				П
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$33.00					Ш	
Services				\$15.00	✓	✓				
				\$35.00		✓				
Imaging (CT/PET Scans, MRIs)				\$35.00						
Speech Therapy				\$25.00	V	V				
Ossusational and Dhusical Thomas				\$25.00	✓	~				
Occupational and Physical Therapy			100%	\$0.00			1000/	¢0.00		
Preventive Care/Screening/Immunization			100%				100%	\$0.00		
Laboratory Outpatient and Professional Services				\$35.00	∨	∨				H
X-rays and Diagnostic Imaging				\$35.00 \$500.00	∨	∨				<u> </u>
Skilled Nursing Facility	Ш	Ш		\$300.00					Ш	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				\$100.00	✓	✓				
						✓				П
Outpatient Surgery Physician/Surgical Services				\$100.00						
Drugs	□ All	AII		440.00	✓ All	✓ All			□ All	All
Generics				\$10.00	V	✓				
Preferred Brand Drugs				\$30.00	<u> </u>	<u>∨</u>				
Non-Preferred Brand Drugs				\$60.00						
Specialty Drugs (i.e. high-cost)				\$60.00	V	✓				
Options for Additional Benefit Design Limits:		1	Plan Description	n:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:							
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:							
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:							
# Days (1-10):			AVC Version:	2024_1e						
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):		J								
Output										
Calculate										
	Calculation Succe	essful.								
	89.60%									
Metal Tier:	Platinum									
	NOTE: Service-sp	ecific cost-sharin	g is applying for	service(s) with fa	c/prof compon	ents, overridir	g outpatient inpu	ts for those se	rvice(s).	
Additional Notes:										
Calculation Time:	0.1406 seconds									
Draft 2024 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option	s	Tie	red Network C				
Apply Inpatient Copay per Day?		HSA/HRA Emplo	yer Contribution	? 🗌	Tiered	Network Plan				
Apply Skilled Nursing Facility Copay per Day?					1st 7	ier Utilization				
Use Separate MOOP for Medical and Drug Spending?		Annual Contril	bution Amount:		2nd 7	ier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier										
	Tier	1 Plan Benefit De	esign		Tier	2 Plan Benefit	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$600.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$5,9	00.00								
MOOP if Separate (\$)				_						
Click Here for Important Instructions		Tie					ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	•	Coinsurance, if	Copay, if	Copay applies	
	Deductible?	Coinsurance?	different	separate		Coinsurance?	different	separate	deduct	
Medical	✓ All	☐ All			✓ All	✓ All			✓ All	☐ All
Emergency Room Services	V			\$150.00	V	V			V	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$1,000.00	✓	✓			V	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and				\$25.00						
X-rays)	✓			\$25.00	✓	✓			✓	
Specialist Visit	_			\$40.00	✓	✓			~	
Mental/Behavioral Health and Substance Use Disorder Outpatient		_		44-44		_		-	_	_
Services	✓			\$25.00	✓	\checkmark			✓	
Imaging (CT/PET Scans, MRIs)	V			\$40.00	✓	V			V	
Speech Therapy	<u> </u>			\$30.00		<u>~</u>			V	
Occupational and Physical Therapy	✓			\$30.00	✓	✓			✓	
Preventive Care/Screening/Immunization			100%	\$0.00			100%	\$0.00		
Laboratory Outpatient and Professional Services	V		100/0	\$40.00			10070	VO.00	V	
X-rays and Diagnostic Imaging	✓			\$40.00		V			<u> </u>	n
Skilled Nursing Facility	V			\$1,000.00		<u> </u>			<u> </u>	
JAMES TACING					-					
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓			\$100.00	✓	\checkmark			✓	
Outpatient Surgery Physician/Surgical Services	V			\$100.00	✓	✓			V	
Drugs	□ All	☐ All			✓ All	✓ All			□AI	☐ All
Generics				\$10.00	V	<u> </u>				
Preferred Brand Drugs				\$35.00	<u> </u>	✓				
Non-Preferred Brand Drugs				\$70.00		<u> </u>				
Specialty Drugs (i.e. high-cost)				\$70.00		<u> </u>				
Options for Additional Benefit Design Limits:			Plan Description	n:				•		
Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:							
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:							
Set a Maximum Number of Days for Charging an IP Copay?		1	Issuer HIOS ID:							
# Days (1-10):			AVC Version:	2024_1e						
Begin Primary Care Cost-Sharing After a Set Number of Visits?		1	7.0000000000000000000000000000000000000	202 1_10						
#Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
#Copays (1-10):										
Output # Copays (1-10).		J								
Calculate										
	Calaulatian C	fl								
Status/Error Messages:	Calculation Succ	esstut.								
Actuarial Value:	81.98%									
Metal Tier:	Gold									
	NOTE: Service-sp	pecific cost-sharin	ig is applying for	service(s) with fa	c/prot compon	ents, overridir	g outpatient input	s for those sei	rvice(s).	
Additional Notes:										
Calculation Time:	0.0625 seconds									
Draft 2024 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			Tie	red Network O	ption					
Apply Inpatient Copay per Day?		HSA/HRA Emplo	yer Contribution?		Tiered	Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Cantail	bution Amount:		1st 7	ier Utilization:	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	bution Amount:		2nd 7	ier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier										
Desired Metal Her		1 Plan Benefit De	esign	1	Tier	2 Plan Benefit	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,100.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		50.00		1						
MOOP if Separate (\$)	+=,			•						
			•				•			
Click Here for Important Instructions		Tie	er 1			Ti	ier 2		Tier 1	Tier 2
Time of Dans St	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applie	s only after
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	deduct	ible?
Medical	V A∥	☐ All			✓ All	✓ All			✓ All	☐ All
Emergency Room Services	>			\$500.00	V	V			>	
All Inpatient Hospital Services (inc. MH/SUD)	>			\$1,500.00	✓	V			V	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and	_	_								
X-rays)	>			\$30.00	✓	✓			V	
Specialist Visit	V			\$65.00	V	V			✓	
Mental/Behavioral Health and Substance Use Disorder Outpatient						·····				
Services	>			\$30.00	✓	✓			✓	
Imaging (CT/PET Scans, MRIs)	>			\$175.00	V	V			✓	
Speech Therapy				\$30.00	<u> </u>				V	
					· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·				·····
Occupational and Physical Therapy	•			\$30.00	✓	✓			✓	
Preventive Care/Screening/Immunization		П	100%	\$0.00			100%	\$0.00		
Laboratory Outpatient and Professional Services]\[\sigma\]		100/0	\$50.00		V	20070	\$0.00	~	
X-rays and Diagnostic Imaging	<u> </u>			\$75.00	<u> </u>	<u> </u>			<u> </u>	
Skilled Nursing Facility	<u> </u>			\$1,500.00	<u> </u>	<u> </u>			$\overline{\mathbf{Z}}$	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	•			\$150.00	✓	✓			✓	
Outpatient Surgery Physician/Surgical Services	V			\$150.00	✓	✓			V	
Drugs	□ All	☐ All			✓ All	✓ All			□AI	☐ All
Generics				\$15.00	✓	V				
Preferred Brand Drugs				\$40.00	✓	V				
Non-Preferred Brand Drugs				\$75.00	✓	<u> </u>				
Specialty Drugs (i.e. high-cost)				\$75.00	V	<u> </u>				
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:							
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:							
Set a Maximum Number of Days for Charging an IP Copay?		1	Issuer HIOS ID:							
# Days (1-10):			AVC Version:	2024_1e						
Begin Primary Care Cost-Sharing After a Set Number of Visits?		1		_						
#Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of	V	1								
Copays?	_									
# Copays (1-10):	1									
Output		,								
Calculate										
	Calculation Succe	essful.								
	71.99%									
	Silver									
		ecific cost-sharin	g is applying for s	ervice(s) with fa	c/prof compon	ents, overridin	g outpatient inpu	ts for those se	rvice(s).	
Additional Notes:			O . 2 CPP. 1111 B 1 O1 3		., p. c. compon		o - a special in pu			
ridditional Hotes.										
Calculation Time:	0.0547 seconds									
Draft 2024 AV Calculator	0.0347 seconus									
Curculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emplo	yer Contribution?		Tiered	Network Plan?				
Apply Skilled Nursing Facility Copay per Day?					1st 7	lier Utilization:	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	oution Amount:		2nd 7	ier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	✓									
Desired Metal Tier	Silver ▼									
		1 Plan Benefit De	sign	1	Tier	2 Plan Benefit	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,925.00	\$0.00	Combined		Wiedream	Diug	combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		50.00		1		I				
MOOP if Separate (\$)	\$1,5	30.00								
MOOP If Separate (\$)			ı							
Click there for leave that has been time.		T-	1			-	2		Tinu 1	T 2
Click Here for Important Instructions		Tie		- "			ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to		Coinsurance, if	Copay, if	Copay applies	
· ·	Deductible?	Coinsurance?	different	separate		Coinsurance?	different	separate	deduct	
Medical	✓ All	□ All			✓ All	✓ All			V AI	All
Emergency Room Services	<u> </u>			\$275.00	V	<u></u>			V	
All Inpatient Hospital Services (inc. MH/SUD)	>			\$1,500.00	✓	V			>	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and				\$30.00	✓	V				
X-rays)	✓			\$30.00		v			V	ш
Specialist Visit	✓			\$65.00	✓	✓			>	
Mental/Behavioral Health and Substance Use Disorder Outpatient	_	_		444	_	_				_
Services	~			\$30.00	✓	✓			✓	
Imaging (CT/PET Scans, MRIs)	V			\$175.00		✓			V	
Speech Therapy	<u> </u>			\$30.00					<u> </u>	
opecar metapy					·					
Occupational and Physical Therapy	>			\$30.00	✓	✓			✓	
Preventive Care/Screening/Immunization			100%	\$0.00			100%	\$0.00		
Laboratory Outpatient and Professional Services			100%	\$50.00		<u> </u>	100%	30.00	V	
	<u> </u>				✓	<u>~</u>			V	
X-rays and Diagnostic Imaging				\$75.00	✓	∨				H
Skilled Nursing Facility	✓			\$1,500.00		<u> </u>			✓	Ш
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓			\$150.00	✓	✓			✓	
	V				. V	V			V	П
Outpatient Surgery Physician/Surgical Services				\$150.00						
Drugs	All	□ All			✓ All	✓ All			□ AI	All
Generics				\$15.00	V	<u>~</u>				
Preferred Brand Drugs				\$40.00	V	✓				
Non-Preferred Brand Drugs				\$75.00	V	<u> </u>				
Specialty Drugs (i.e. high-cost)				\$75.00	▽	✓				
Options for Additional Benefit Design Limits:		_	Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:							
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:							
Set a Maximum Number of Days for Charging an IP Copay?]	Issuer HIOS ID:							
# Days (1-10):			AVC Version:	2024_1e						
Begin Primary Care Cost-Sharing After a Set Number of Visits?		1		_						
#Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of	7	1								
Copays?										
# Copays (1-10):	1									
Output		J								
Calculate	CCD (=========================	(200 2500/ 55:)	Callandada a Commo							
		(200-250% FPL), (Laiculation Succes	sstui.						
	73.99%									
	Silver									
	NOTE: Service-sp	ecific cost-sharin	g is applying for s	ervice(s) with fa	c/prof compon	ents, overridin	g outpatient inpu	ts for those se	rvice(s).	
Additional Notes:										
Calculation Time:	0.0664 seconds									
Draft 2024 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emplo	yer Contribution?	? 🗆	Tiered	Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Cantail	bution Amount:		1st 7	ier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Affilial Contin	button Amount:		2nd 7	ier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard? Desired Metal Tier										
Desired Wetar Her		r 1 Plan Benefit De	esign		Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$275.00	\$0.00	Communica		1110 011001					
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		50.00								
MOOP if Separate (\$)				-						
			•				•			
Click Here for Important Instructions		Tie	er 1			Ti	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 applie	s only after
туре от венепт	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	deduct	ible?
Medical	✓ All	☐ All			✓ All	✓ All			✓ All	☐ All
Emergency Room Services	V			\$75.00	~	V			>	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$250.00		V			V	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and		_		* **		_			_	
X-rays)	✓			\$15.00	✓	✓			✓	
Specialist Visit	V			\$35.00	V	~			✓	
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services	✓			\$15.00	✓	✓			✓	
Imaging (CT/PET Scans, MRIs)	✓			\$35.00		✓			✓	
Speech Therapy	v			\$25.00		_ _			<u> </u>	
opecar merapy										
Occupational and Physical Therapy	✓			\$25.00	✓	✓			✓	
Preventive Care/Screening/Immunization			100%	\$0.00			100%	\$0.00		
Laboratory Outpatient and Professional Services	V		100%	\$35.00		<u> </u>	100%	\$0.00	V	
	V			\$35.00		<u>.</u>			V	
X-rays and Diagnostic Imaging	V			\$250.00	✓	<u>v</u>			V	
Skilled Nursing Facility		Ш		\$250.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓			\$75.00	✓	✓			V	
Outpatient Surgery Physician/Surgical Services	V			\$75.00	✓	~			>	
Drugs	□ All	☐ All			✓ All	✓ All			□AI	☐ All
Generics				\$9.00	V	~				
Preferred Brand Drugs				\$20.00	✓	✓				
Non-Preferred Brand Drugs				\$40.00	✓	✓				
Specialty Drugs (i.e. high-cost)				\$40.00	Y	~				
Options for Additional Benefit Design Limits:			Plan Description	n:						
Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:							
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:							
Set a Maximum Number of Days for Charging an IP Copay?		1	Issuer HIOS ID:							
# Days (1-10):			AVC Version:	2024_1e						
Begin Primary Care Cost-Sharing After a Set Number of Visits?		1		_						
#Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of	V	1								
Copays?										
#Copays (1-10):	1									
Output		J								
Calculate										
Status/Error Messages:	CSR Level of 97%	(150-200% FPL),	Calculation Succe	ssful						
Actuarial Value:	87.98%	, (150 200/01 FL), (Carcalation sacce	Jordi.						
Metal Tier:	Gold									
Metal Itel.		oecific cost-sharin	a is applying for	carvica(s) with fa	c/prof compos	ante overridia	a outpatient innu	e for those so	nvice(s)	
Additional Nation	NOTE: Service-sp	Jeci IC COST-SHAFIF	ig is applying for s	service(s) with ta	c/prorcompon	ents, overnain	s outpatient inpu	is for those se	ivice(s).	
Additional Notes:										
Calculation Time: Draft 2024 AV Calculator	0.0547 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	red Network C	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emplo	yer Contribution?	? 🗆	Tiered	Network Plan				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization				
Use Separate MOOP for Medical and Drug Spending?		Annual contin	batton Amount.		2nd	Tier Utilization				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier										
		1 Plan Benefit De		-		2 Plan Benefit				
0.1.491.76	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$) Coinsurance (%, Insurer's Cost Share)	\$0.00 100.00%	\$0.00 100.00%								
MOOP (\$)		00.00		-						
MOOP (\$)	\$1,0	1								
WOOF II Separate (5)							•			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applie	s only after
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	deduct	ible?
Medical	□ All	☐ All			✓ All	✓ All			□AⅡ	All
Emergency Room Services				\$50.00	V	V				
All Inpatient Hospital Services (inc. MH/SUD)				\$100.00	V	✓				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and				\$10.00	▽	V				
X-rays)				\$10.00						
Specialist Visit				\$20.00	V	V				
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$10.00	✓	✓				
Services										_
Imaging (CT/PET Scans, MRIs)				\$20.00	_	_				
Speech Therapy				\$15.00	V	~				
Occupational and Bhusical Thomas				\$15.00	✓	~				
Occupational and Physical Therapy Preventive Care/Screening/Immunization			100%	\$0.00			100%	\$0.00		
Laboratory Outpatient and Professional Services			100%	\$20.00		<u> </u>	100%	30.00		
X-rays and Diagnostic Imaging				\$20.00		<u> </u>				
Skilled Nursing Facility				\$100.00	V	V				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				\$25.00	✓	~				
Outpatient Surgery Physician/Surgical Services				\$25.00	V	V				
Drugs	□ All	☐ All			✓ All	✓ All			□AI	☐ All
Generics				\$6.00	V	V				
Preferred Brand Drugs				\$15.00	V	V				
Non-Preferred Brand Drugs				\$30.00	<u> </u>	<u> </u>				
Specialty Drugs (i.e. high-cost)				\$30.00	V	~				
Options for Additional Benefit Design Limits:		1	Plan Description	1:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:							
Specialty Rx Coinsurance Maximum: Set a Maximum Number of Days for Charging an IP Copay?		-	Plan HIOS ID: Issuer HIOS ID:							
#Days (1-10):			AVC Version:	2024 1e						
Begin Primary Care Cost-Sharing After a Set Number of Visits?		1	Avc version.	2024_16						
#Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):										
Output		•								
Calculate										
Status/Error Messages:	CSR Level of 94%	(100-150% FPL), (Calculation Succe	ssful.						
Actuarial Value:	94.74%									
Metal Tier:	Platinum									
	NOTE: Service-sp	ecific cost-sharin	g is applying for s	service(s) with fa	c/prof compon	ents, overridir	g outpatient inpu	ts for those se	vice(s).	
Additional Notes:										
Calculation Time:	0.0547 seconds									

Draft 2024 AV Calculator

User Inputs for Plan Parameters											
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options	;	Tie	red Network O	ption				
Apply Inpatient Copay per Day?		HSA/HRA Employ	yer Contribution?		Tiered	Network Plan?					
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	oution Amount:		1st 7	Tier Utilization:					
Use Separate MOOP for Medical and Drug Spending?		Annual Continu	oution Amount:		2nd 7	Tier Utilization:					
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?											
Desired Metal Tier				_							
	Tier	1 Plan Benefit De	sign		Tier	2 Plan Benefit [Design				
	Medical	Drug	Combined		Medical	Drug	Combined				
Deductible (\$)			\$4,600.00								
Coinsurance (%, Insurer's Cost Share)			100.00%	_							
MOOP (\$)			\$9,450.00								
MOOP if Separate (\$)			J								
Click Here for Important Instructions		Tie	r 1			Tie	er 2		Tier 1	Tier 2	
CHECK HETE TOT IMPORTANCE INSURCEIONS	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to		Coinsurance, if	Copay, if	Copay applies only after		
Type of Benefit	Deductible?	Coinsurance?	different	separate		Coinsurance?	different	separate	deduc		
Medical	✓ All	□ All	unterent	эсрагасс	✓ All	✓ All	unterent	3c parace	✓ All	☐ All	
Emergency Room Services	<u> </u>			\$500.00	V	<u> </u>			<u> </u>		
All Inpatient Hospital Services (inc. MH/SUD)	<u> </u>			\$1,500.00		_ _			<u> </u>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and					-						
X-rays)	~			\$50.00	✓	✓			✓		
Specialist Visit	V			\$75.00		✓			V		
Mental/Behavioral Health and Substance Use Disorder Outpatient						·····					
Services	✓			\$50.00	✓	✓			✓		
Imaging (CT/PET Scans, MRIs)	~			\$175.00		✓			V		
Speech Therapy	<u> </u>			\$50.00		_ _			<u> </u>		
Occupational and Physical Therapy	•			\$50.00	~	✓			V		
Preventive Care/Screening/Immunization		П	100%	\$0.00			100%	\$0.00			
Laboratory Outpatient and Professional Services			20070	\$50.00			200,0	V 0.00	V		
X-rays and Diagnostic Imaging	<u> </u>			\$75.00		<u></u>			v		
Skilled Nursing Facility	<u> </u>			\$1,500.00		<u></u>			<u> </u>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	•			\$150.00	~	~			V		
Outpatient Surgery Physician/Surgical Services	V			\$150.00		V			V		
Drugs	✓ All	☐ All			✓ All	✓ All			✓ All	☐ All	
Generics	V			\$10.00	~	V			V		
Preferred Brand Drugs	✓			\$35.00	✓	V			V		
Non-Preferred Brand Drugs	✓			\$70.00	✓	✓			V		
Specialty Drugs (i.e. high-cost)	~			\$70.00	~	V			V		
Options for Additional Benefit Design Limits:			Plan Description	:							
Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:								
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:								
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:								
# Days (1-10):			AVC Version:	2024_1e							
Begin Primary Care Cost-Sharing After a Set Number of Visits?		1									
# Visits (1-10):											
Begin Primary Care Deductible/Coinsurance After a Set Number of	~										
Copays?											
# Copays (1-10):	3										
Output											
Calculate											
Status/Error Messages:	Expanded Bronze	e Standard (58% to	o 65%), Calculatio	n Successful.							
Actuarial Value:	64.95%										
	Bronze										
	NOTE: Service-sp	ecific cost-sharin	g is applying for s	ervice(s) with fa	c/prof compon	ents, overriding	g outpatient inpu	ts for those se	ervice(s).		
Additional Notes:											
Calculation Time:	0.1172 seconds										
Draft 2024 AV Calculator											

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?		ı	HSA/HRA Options	5	Tie	red Network O	otion			
Apply Inpatient Copay per Day?		HSA/HRA Employ	yer Contribution ?	? 🗆		Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	oution Amount:			ier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Tilliaar contin			2nd T	ier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	✓									
Desired Metal Tier				П						
		1 Plan Benefit De		4		2 Plan Benefit [
	Medical	Drug	Combined	4	Medical	Drug	Combined			
Deductible (\$)			\$6,100.00							
Coinsurance (%, Insurer's Cost Share)			50.00%	-						
MOOP (\$)		1	\$7,150.00							
MOOP if Separate (\$)			l							
Click Here for Important Instructions		Tie	r1			Tie	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	•	Coinsurance, if	Copay, if	Copay applies	
Medical	Deductible? ✓ Al	Coinsurance?	different	separate	✓ All	Coinsurance?	different	separate	deduct	All
Emergency Room Services	<u> </u>	<u> </u>			V AII	V				
All Inpatient Hospital Services (inc. MH/SUD)	V	<u> </u>				☑				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and					-					
X-rays)	~	~			✓	✓				
Specialist Visit	V	V			<u> </u>	✓				
Mental/Behavioral Health and Substance Use Disorder Outpatient		***************************************			1				***************************************	
Services	~	~			✓	✓				
Imaging (CT/PET Scans, MRIs)	V	~			~	✓				
Speech Therapy	<u> </u>	<u> </u>								
										·····
Occupational and Physical Therapy	✓	✓			~	✓				
Preventive Care/Screening/Immunization			100%	\$0.00			100%	\$0.00		
Laboratory Outpatient and Professional Services	~	~			<u> </u>	<u> </u>				
X-rays and Diagnostic Imaging	>	V			✓	✓				
Skilled Nursing Facility	>	>				✓				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓	***************************************		V	~				
Outrotion Communication (Comming Comming	V	V				✓				
Outpatient Surgery Physician/Surgical Services	▼ All	AI			✓ All	✓ All			✓ All	AII
Drugs Generics	<u> </u>			\$10.00	V All	V All			V	
Preferred Brand Drugs	<u> </u>			\$35.00		✓			☑	
Non-Preferred Brand Drugs	<u> </u>			\$70.00		V			V	
Specialty Drugs (i.e. high-cost)	<u> </u>			\$70.00		V			☑	П
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?	П	1	Name:							
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:							
Set a Maximum Number of Days for Charging an IP Copay?		1	Issuer HIOS ID:							
# Days (1-10):			AVC Version:	2024_1e						
Begin Primary Care Cost-Sharing After a Set Number of Visits?		1		_						
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:		e Standard (58% to	o 65%), Calculatio	n Successful.						
Actuarial Value:	64.94%									
Metal Tier:	Bronze									
Additional Notes:										
Calculation Time:	0.0469 seconds									
Draft 2024 AV Calculator										