



DEPARTMENT OF

**Professional &  
Financial Regulation**

STATE OF MAINE

- OFFICE OF SECURITIES
- BUREAU OF INSURANCE
- CONSUMER CREDIT PROTECTION
- BUREAU OF FINANCIAL INSTITUTIONS
- OFFICE OF PROF. AND OCC. REGULATION

# **ME BUREAU OF INSURANCE PLAN YEAR 2027 AV SCREENSHOTS**

PREPARED BY THE MAINE BUREAU OF INSURANCE

MARCH 2026

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GOVERNOR

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# CLEAR CHOICE: BRONZE \$7,000 HSA

## 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? <input type="checkbox"/> | Tiered Network Plan? <input type="checkbox"/>  |
| Annual Contribution Amount:                             | 1st Tier Utilization:<br>2nd Tier Utilization: |

| Tier 1 Plan Benefit Design |      |                                               |
|----------------------------|------|-----------------------------------------------|
| Medical                    | Drug | Combined                                      |
|                            |      | Deductible (\$) \$7,000.00                    |
|                            |      | Coinsurance (% , Insurer's Cost Share) 50.00% |
|                            |      | MOOP (\$) \$10,000.00                         |
|                            |      | MOOP if Separate (\$)                         |

| Tier 2 Plan Benefit Design |      |          |
|----------------------------|------|----------|
| Medical                    | Drug | Combined |
|                            |      |          |
|                            |      |          |
|                            |      |          |

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| Type of Benefit                                                                | Tier 1                                  |                                         |                           |                    | Tier 2                                  |                                         |                           |                    | Tier 1                               | Tier 2                       |
|--------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|--------------------------------------|------------------------------|
|                                                                                | 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? |                              |
| <b>Medical</b>                                                                 | <input checked="" type="checkbox"/> All | <input type="checkbox"/> All            |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All |
| Emergency Room Services                                                        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| All Inpatient Hospital Services (inc. MH/SUD)                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays) | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$45.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Specialist Visit                                                               | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Mental/Behavioral Health and Substance Use Disorder Outpatient Services        | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$45.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Imaging (CT/PET Scans, MRIs)                                                   | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Speech Therapy                                                                 | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$45.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Occupational and Physical Therapy                                              | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$45.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Preventive Care/Screening/Immunization                                         | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Laboratory Outpatient and Professional Services                                | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| X-rays and Diagnostic Imaging                                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Skilled Nursing Facility                                                       | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Outpatient Surgery Physician/Surgical Services                                 | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| <b>Drugs</b>                                                                   | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All |
| Generics                                                                       | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$30.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Preferred Brand Drugs                                                          | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Non-Preferred Brand Drugs                                                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Specialty Drugs (i.e. high-cost)                                               | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |

### Options for Additional Benefit Design Limits:

|                                                                         |                                     |
|-------------------------------------------------------------------------|-------------------------------------|
| Set a Maximum on Specialty Rx Coinsurance Payments?                     | <input type="checkbox"/>            |
| Specialty Rx Coinsurance Maximum:                                       |                                     |
| Set a Maximum Number of Days for Charging an IP Copay?                  | <input type="checkbox"/>            |
| # Days (1-10):                                                          |                                     |
| Begin Primary Care Cost-Sharing After a Set Number of Visits?           | <input checked="" type="checkbox"/> |
| # Visits (1-10):                                                        | 1                                   |
| Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? | <input type="checkbox"/>            |
| # Copays (1-10):                                                        |                                     |

### Plan Description:

Name:  
 Plan HIOS ID:  
 Issuer HIOS ID:  
 AVC Version: 2027\_1b

### Output

Calculate

Status/Error Messages:

Expanded Bronze Standard (58% to 65%), Calculation Successful.

Actuarial Value:

64.16%

Metal Tier:

Bronze

NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Additional Notes:

Calculation Time:

0.041 seconds

Final 2027 AV Calculator

# CLEAR CHOICE: BRONZE \$8,700 HSA

**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? | <input type="checkbox"/> | Tiered Network Plan?  | <input type="checkbox"/> |
| Annual Contribution Amount:    |                          | 1st Tier Utilization: |                          |
|                                |                          | 2nd Tier Utilization: |                          |

  

|                                      | Tier 1 Plan Benefit Design |      |            | Tier 2 Plan Benefit Design |      |          |
|--------------------------------------|----------------------------|------|------------|----------------------------|------|----------|
|                                      | Medical                    | Drug | Combined   | Medical                    | Drug | Combined |
| Deductible (\$)                      |                            |      | \$8,700.00 |                            |      |          |
| Coinsurance (% Insurer's Cost Share) |                            |      | 100.00%    |                            |      |          |
| MOOP (\$)                            |                            |      | \$8,700.00 |                            |      |          |
| MOOP if Separate (\$)                |                            |      |            |                            |      |          |

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| Type of Benefit                                                         | Tier 1                                  |                                         |                           |                    | Tier 2                                  |                                         |                           |                    | Tier 1                               | Tier 2                               |
|-------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|--------------------------------------|--------------------------------------|
|                                                                         | 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? | Copay applies only after deductible? |
| <b>Medical</b>                                                          | <input checked="" type="checkbox"/> All | <input type="checkbox"/> All            |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All         |
| Emergency Room Services                                                 | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| All Inpatient Hospital Services (inc. MH/SUD)                           | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)       | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Specialist Visit                                                        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Mental/Behavioral Health and Substance Use Disorder Outpatient Services | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Imaging (CT/PET Scans, MRIs)                                            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Speech Therapy                                                          | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| and Physical Therapy                                                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Preventive Care/Screening/Immunization                                  | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Laboratory Outpatient and Professional Services                         | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| X-rays and Diagnostic Imaging                                           | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Skilled Nursing Facility                                                | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Facility Fee (e.g., Ambulatory Surgery Center)                          | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Surgeon Physician/Surgical Services                                     | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| <b>Drugs</b>                                                            | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All         |
| Generics                                                                | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Preferred Brand Drugs                                                   | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Non-Preferred Brand Drugs                                               | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Specialty Drugs (i.e. high-cost)                                        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |

  

| Options for Additional Benefit Design Limits:                           |                          | Plan Description: |         |
|-------------------------------------------------------------------------|--------------------------|-------------------|---------|
| Set a Maximum on Specialty Rx Coinsurance Payments?                     | <input type="checkbox"/> | Name:             |         |
| Specialty Rx Coinsurance Maximum:                                       |                          | Plan HIOS ID:     |         |
| Set a Maximum Number of Days for Charging an IP Copay?                  | <input type="checkbox"/> | Issuer HIOS ID:   |         |
| # Days (1-10):                                                          |                          | AVC Version:      | 2027_1b |
| Begin Primary Care Cost-Sharing After a Set Number of Visits?           | <input type="checkbox"/> |                   |         |
| # Visits (1-10):                                                        |                          |                   |         |
| Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? | <input type="checkbox"/> |                   |         |
| # Copays (1-10):                                                        |                          |                   |         |

  

**Output**

Calculate

Status/Error Messages: Expanded Bronze Standard (58% to 65%), Calculation Successful.  
 Actuarial Value: 63.16%  
 Metal Tier: Bronze

Additional Notes:

Calculation Time: 0.2715 seconds  
**Final 2027 AV Calculator**

# CLEAR CHOICE: BRONZE \$7,500 HSA

## 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? <input type="checkbox"/> | Tiered Network Plan? <input type="checkbox"/> |
| Annual Contribution Amount:                             | 1st Tier Utilization:                         |
|                                                         | 2nd Tier Utilization:                         |

|                                     | Tier 1 Plan Benefit Design |      |             | Tier 2 Plan Benefit Design |      |          |
|-------------------------------------|----------------------------|------|-------------|----------------------------|------|----------|
|                                     | Medical                    | Drug | Combined    | Medical                    | Drug | Combined |
| Deductible (\$)                     |                            |      | \$7,500.00  |                            |      |          |
| Coinurance (% Insurer's Cost Share) |                            |      | 50.00%      |                            |      |          |
| MOOP (\$)                           |                            |      | \$12,000.00 |                            |      |          |
| MOOP if Separate (\$)               |                            |      |             |                            |      |          |

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| Type of Benefit                                                                | Tier 1                                  |                                         |                          |                    | Tier 2                                  |                                         |                          |                    | Tier 1                               | Tier 2                               |
|--------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|--------------------------|--------------------|-----------------------------------------|-----------------------------------------|--------------------------|--------------------|--------------------------------------|--------------------------------------|
|                                                                                | Subject to Deductible?                  | Subject to Coinsurance?                 | Coinurance, if different | Copay, if separate | Subject to Deductible?                  | Subject to Coinsurance?                 | Coinurance, if different | Copay, if separate | Copay applies only after deductible? | Copay applies only after deductible? |
| <b>Medical</b>                                                                 | <input checked="" type="checkbox"/> All | <input type="checkbox"/> All            |                          |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                          |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All         |
| Emergency Room Services                                                        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| All Inpatient Hospital Services (inc. MH/SUD)                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays) | <input type="checkbox"/>                | <input type="checkbox"/>                |                          | \$45.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Specialist Visit                                                               | <input type="checkbox"/>                | <input type="checkbox"/>                |                          | \$80.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Mental/Behavioral Health and Substance Use Disorder Outpatient Services        | <input type="checkbox"/>                | <input type="checkbox"/>                |                          | \$45.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Imaging (CT/PET Scans, MRIs)                                                   | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Speech Therapy                                                                 | <input type="checkbox"/>                | <input type="checkbox"/>                |                          | \$45.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Occupational and Physical Therapy                                              | <input type="checkbox"/>                | <input type="checkbox"/>                |                          | \$45.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Preventive Care/Screening/Immunization                                         | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                     | \$0.00             | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                     | \$0.00             | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Laboratory Outpatient and Professional Services                                | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| X-rays and Diagnostic Imaging                                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Skilled Nursing Facility                                                       | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Outpatient Surgery Physician/Surgical Services                                 | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| <b>Drugs</b>                                                                   | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                          |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                          |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All         |
| Generics                                                                       | <input type="checkbox"/>                | <input type="checkbox"/>                |                          | \$30.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Preferred Brand Drugs                                                          | <input checked="" type="checkbox"/>     | <input type="checkbox"/>                |                          | \$50.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input checked="" type="checkbox"/>  | <input type="checkbox"/>             |
| Non-Preferred Brand Drugs                                                      | <input checked="" type="checkbox"/>     | <input type="checkbox"/>                |                          | \$100.00           | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input checked="" type="checkbox"/>  | <input type="checkbox"/>             |
| Specialty Drugs (i.e. high-cost)                                               | <input checked="" type="checkbox"/>     | <input type="checkbox"/>                |                          | \$250.00           | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                          |                    | <input checked="" type="checkbox"/>  | <input type="checkbox"/>             |

### Options for Additional Benefit Design Limits:

|                                                                         |                                     |
|-------------------------------------------------------------------------|-------------------------------------|
| Set a Maximum on Specialty Rx Coinsurance Payments?                     | <input type="checkbox"/>            |
| Specialty Rx Coinsurance Maximum:                                       |                                     |
| Set a Maximum Number of Days for Charging an IP Copay?                  | <input type="checkbox"/>            |
| # Days (1-10):                                                          |                                     |
| Begin Primary Care Cost-Sharing After a Set Number of Visits?           | <input checked="" type="checkbox"/> |
| # Visits (1-10):                                                        | 1                                   |
| Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? | <input type="checkbox"/>            |
| # Copays (1-10):                                                        |                                     |

### Plan Description:

Name:  
 Plan HIOS ID:  
 Issuer HIOS ID:  
 AVC Version: 2027\_1b

### Output

Calculate

Status/Error Messages:

Error: Result is outside of [-2, +2] percent de minimis variation.

Actuarial Value:

63.86%

Metal Tier:

NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Additional Notes:

Calculation Time:

0.0391 seconds

Final 2027 AV Calculator

# CLEAR CHOICE: SILVER \$4,000 HSA

**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? | <input type="checkbox"/> | Tiered Network Plan?  | <input type="checkbox"/> |
| Annual Contribution Amount:    |                          | 1st Tier Utilization: |                          |
|                                |                          | 2nd Tier Utilization: |                          |

| Tier 1 Plan Benefit Design           |      |            | Tier 2 Plan Benefit Design |      |          |
|--------------------------------------|------|------------|----------------------------|------|----------|
| Medical                              | Drug | Combined   | Medical                    | Drug | Combined |
| Deductible (\$)                      |      | \$4,000.00 |                            |      |          |
| Coinsurance (% Insurer's Cost Share) |      | 80.00%     |                            |      |          |
| MOOP (\$)                            |      | \$8,700.00 |                            |      |          |
| MOOP if Separate (\$)                |      |            |                            |      |          |

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| Type of Benefit                                                                | Tier 1                                  |                                         |                           |                    | Tier 2                                  |                                         |                           |                    | Tier 1                               | Tier 2                               |
|--------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|--------------------------------------|--------------------------------------|
|                                                                                | 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? | Copay applies only after deductible? |
| <b>Medical</b>                                                                 | <input checked="" type="checkbox"/> All | <input type="checkbox"/> All            |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All         |
| Emergency Room Services                                                        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| All Inpatient Hospital Services (inc. MH/SUD)                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays) | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Specialist Visit                                                               | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Mental/Behavioral Health and Substance Use Disorder Outpatient Services        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Imaging (CT/PET Scans, MRIs)                                                   | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Speech Therapy                                                                 | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Occupational and Physical Therapy                                              | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Preventive Care/Screening/Immunization                                         | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Laboratory Outpatient and Professional Services                                | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| X-rays and Diagnostic Imaging                                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Skilled Nursing Facility                                                       | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Outpatient Surgery Physician/Surgical Services                                 | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| <b>Drugs</b>                                                                   | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All         |
| Generics                                                                       | <input checked="" type="checkbox"/>     | <input type="checkbox"/>                |                           | \$25.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>  | <input type="checkbox"/>             |
| Preferred Brand Drugs                                                          | <input checked="" type="checkbox"/>     | <input type="checkbox"/>                |                           | \$50.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>  | <input type="checkbox"/>             |
| Non-Preferred Brand Drugs                                                      | <input checked="" type="checkbox"/>     | <input type="checkbox"/>                |                           | \$100.00           | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>  | <input type="checkbox"/>             |
| Specialty Drugs (i.e. high-cost)                                               | <input checked="" type="checkbox"/>     | <input type="checkbox"/>                |                           | \$250.00           | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>  | <input type="checkbox"/>             |

**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:  
 Plan HIOS ID:  
 Issuer HIOS ID:  
 AVC Version: 2027\_1b

**Output**

Calculate

Status/Error Messages: Calculation Successful.  
 Actuarial Value: 70.64%  
 Metal Tier: Silver

Additional Notes:

Calculation Time: 0.0625 seconds  
**Final 2027 AV Calculator**

# CLEAR CHOICE: SILVER \$6,000

**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

| Tier 1 Plan Benefit Design           |      |             |
|--------------------------------------|------|-------------|
| Medical                              | Drug | Combined    |
| Deductible (\$)                      |      | \$6,000.00  |
| Coinsurance (% Insurer's Cost Share) |      | 70.00%      |
| MOOP (\$)                            |      | \$10,000.00 |
| MOOP if Separate (\$)                |      |             |

| Tier 2 Plan Benefit Design |      |          |
|----------------------------|------|----------|
| Medical                    | Drug | Combined |
|                            |      |          |
|                            |      |          |
|                            |      |          |

| Type of Benefit                                                                | Tier 1                                  |                                         |                           |                    | Tier 2                                  |                                         |                           |                    | Tier 1                               | Tier 2                               |
|--------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|--------------------------------------|--------------------------------------|
|                                                                                | 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? | Copay applies only after deductible? |
| <b>Medical</b>                                                                 | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All         |
| Emergency Room Services                                                        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| All Inpatient Hospital Services (inc. MH/SUD)                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays) | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Specialist Visit                                                               | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$60.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Mental/Behavioral Health and Substance Use Disorder Outpatient Services        | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Imaging (CT/PET Scans, MRIs)                                                   | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Speech Therapy                                                                 | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Occupational and Physical Therapy                                              | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Preventive Care/Screening/Immunization                                         | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Laboratory Outpatient and Professional Services                                | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| X-rays and Diagnostic Imaging                                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Skilled Nursing Facility                                                       | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Outpatient Surgery Physician/Surgical Services                                 | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| <b>Drugs</b>                                                                   | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All         |
| Generics                                                                       | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$25.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Preferred Brand Drugs                                                          | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$50.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Non-Preferred Brand Drugs                                                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Specialty Drugs (i.e. high-cost)                                               | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     | 50%                       |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |

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

**Plan Description:**  
 Name: \_\_\_\_\_  
 Plan HIOS ID: \_\_\_\_\_  
 Issuer HIOS ID: \_\_\_\_\_  
 AVC Version: 2027\_1b

**Output**

Calculate

Status/Error Messages: Calculation Successful.  
 Actuarial Value: 70.70%  
 Metal Tier: Silver  
 NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Additional Notes:

Calculation Time: 0.043 seconds

Final 2027 AV Calculator

# CLEAR CHOICE: SILVER \$6,000 CSR 73%

## 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? <input type="checkbox"/> | Tiered Network Plan? <input type="checkbox"/>  |
| Annual Contribution Amount:                             | 1st Tier Utilization:<br>2nd Tier Utilization: |

| Tier 1 Plan Benefit Design             |      |            |
|----------------------------------------|------|------------|
| Medical                                | Drug | Combined   |
| Deductible (\$)                        |      | \$4,500.00 |
| Coinsurance (% , Insurer's Cost Share) |      | 70.00%     |
| MOOP (\$)                              |      | \$8,000.00 |
| MOOP if Separate (\$)                  |      |            |

| Tier 2 Plan Benefit Design             |      |          |
|----------------------------------------|------|----------|
| Medical                                | Drug | Combined |
| Deductible (\$)                        |      |          |
| Coinsurance (% , Insurer's Cost Share) |      |          |
| MOOP (\$)                              |      |          |
| MOOP if Separate (\$)                  |      |          |

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| Type of Benefit                                                                | Tier 1                                  |                                         |                           |                    | Tier 2                                  |                                         |                           |                    | Tier 1                               | Tier 2                       |
|--------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|--------------------------------------|------------------------------|
|                                                                                | 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? |                              |
| <b>Medical</b>                                                                 | <input checked="" type="checkbox"/> All | <input type="checkbox"/> All            |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All |
| Emergency Room Services                                                        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| All Inpatient Hospital Services (inc. MH/SUD)                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays) | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Specialist Visit                                                               | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$60.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Mental/Behavioral Health and Substance Use Disorder Outpatient Services        | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Imaging (CT/PET Scans, MRIs)                                                   | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Speech Therapy                                                                 | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Occupational and Physical Therapy                                              | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Preventive Care/Screening/Immunization                                         | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Laboratory Outpatient and Professional Services                                | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| X-rays and Diagnostic Imaging                                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Skilled Nursing Facility                                                       | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Outpatient Surgery Physician/Surgical Services                                 | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| <b>Drugs</b>                                                                   | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All |
| Generics                                                                       | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$25.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Preferred Brand Drugs                                                          | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$50.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Non-Preferred Brand Drugs                                                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Specialty Drugs (i.e. high-cost)                                               | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     | 50%                       |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |

### Options for Additional Benefit Design Limits:

|                                                                         |                                     |
|-------------------------------------------------------------------------|-------------------------------------|
| Set a Maximum on Specialty Rx Coinsurance Payments?                     | <input type="checkbox"/>            |
| Specialty Rx Coinsurance Maximum:                                       |                                     |
| Set a Maximum Number of Days for Charging an IP Copay?                  | <input type="checkbox"/>            |
| # Days (1-10):                                                          |                                     |
| Begin Primary Care Cost-Sharing After a Set Number of Visits?           | <input checked="" type="checkbox"/> |
| # Visits (1-10):                                                        | 1                                   |
| Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? | <input type="checkbox"/>            |
| # Copays (1-10):                                                        |                                     |

### Plan Description:

Name:  
Plan HIOS ID:  
Issuer HIOS ID:  
AVC Version: 2027\_1b

### Output

Calculate

Status/Error Messages:

CSR Level of 73% (200-250% FPL), Calculation Successful.

Actuarial Value:

73.55%

Metal Tier:

Silver

NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Additional Notes:

Calculation Time:

0.0469 seconds

Final 2027 AV Calculator

# CLEAR CHOICE: SILVER \$6,000 CSR 87%

## 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? <input type="checkbox"/> | Tiered Network Plan? <input type="checkbox"/>  |
| Annual Contribution Amount:                             | 1st Tier Utilization:<br>2nd Tier Utilization: |

|                                      | Tier 1 Plan Benefit Design |      |            | Tier 2 Plan Benefit Design |      |          |
|--------------------------------------|----------------------------|------|------------|----------------------------|------|----------|
|                                      | Medical                    | Drug | Combined   | Medical                    | Drug | Combined |
| Deductible (\$)                      |                            |      | \$1,000.00 |                            |      |          |
| Coinsurance (% Insurer's Cost Share) |                            |      | 70.00%     |                            |      |          |
| MOOP (\$)                            |                            |      | \$2,300.00 |                            |      |          |
| MOOP if Separate (\$)                |                            |      |            |                            |      |          |

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| Type of Benefit                                                                | Tier 1                                  |                                         |                           |                    | Tier 2                                  |                                         |                           |                    | Tier 1                               | Tier 2                               |
|--------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|--------------------------------------|--------------------------------------|
|                                                                                | 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? | Copay applies only after deductible? |
| <b>Medical</b>                                                                 | <input checked="" type="checkbox"/> All | <input type="checkbox"/> All            |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All         |
| Emergency Room Services                                                        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| All Inpatient Hospital Services (inc. MH/SUD)                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays) | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Specialist Visit                                                               | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$60.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Mental/Behavioral Health and Substance Use Disorder Outpatient Services        | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Imaging (CT/PET Scans, MRIs)                                                   | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Speech Therapy                                                                 | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Occupational and Physical Therapy                                              | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Preventive Care/Screening/Immunization                                         | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Laboratory Outpatient and Professional Services                                | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| X-rays and Diagnostic Imaging                                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Skilled Nursing Facility                                                       | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Outpatient Surgery Physician/Surgical Services                                 | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| <b>Drugs</b>                                                                   | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All         |
| Generics                                                                       | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$25.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Preferred Brand Drugs                                                          | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$50.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Non-Preferred Brand Drugs                                                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Specialty Drugs (i.e. high-cost)                                               | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     | 50%                       |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |

### Options for Additional Benefit Design Limits:

|                                                                         |                                     |
|-------------------------------------------------------------------------|-------------------------------------|
| Set a Maximum on Specialty Rx Coinsurance Payments?                     | <input type="checkbox"/>            |
| Specialty Rx Coinsurance Maximum:                                       |                                     |
| Set a Maximum Number of Days for Charging an IP Copay?                  | <input type="checkbox"/>            |
| # Days (1-10):                                                          |                                     |
| Begin Primary Care Cost-Sharing After a Set Number of Visits?           | <input checked="" type="checkbox"/> |
| # Visits (1-10):                                                        | 1                                   |
| Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? | <input type="checkbox"/>            |
| # Copays (1-10):                                                        |                                     |

### Plan Description:

Name:  
Plan HIOS ID:  
Issuer HIOS ID:  
AVC Version: 2027\_1b

### Output

Status/Error Messages: CSR Level of 87% (150-200% FPL), Calculation Successful.  
Actuarial Value: 87.50%  
Metal Tier: Gold  
NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Additional Notes:

Calculation Time: 0.0469 seconds

Final 2027 AV Calculator

# CLEAR CHOICE: SILVER \$6,000 CSR 94%

**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? | <input type="checkbox"/> | Tiered Network Plan?  | <input type="checkbox"/> |
| Annual Contribution Amount:    |                          | 1st Tier Utilization: |                          |
|                                |                          | 2nd Tier Utilization: |                          |

|                                      | Tier 1 Plan Benefit Design |      |            | Tier 2 Plan Benefit Design |      |          |
|--------------------------------------|----------------------------|------|------------|----------------------------|------|----------|
|                                      | Medical                    | Drug | Combined   | Medical                    | Drug | Combined |
| Deductible (\$)                      |                            |      | \$500.00   |                            |      |          |
| Coinsurance (% Insurer's Cost Share) |                            |      | 75.00%     |                            |      |          |
| MOOP (\$)                            |                            |      | \$1,200.00 |                            |      |          |
| MOOP if Separate (\$)                |                            |      |            |                            |      |          |

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| Type of Benefit                                                                | Tier 1                                  |                                         |                           |                    | Tier 2                                  |                                         |                           |                    | Tier 1                               | Tier 2                               |
|--------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|--------------------------------------|--------------------------------------|
|                                                                                | 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? | Copay applies only after deductible? |
| <b>Medical</b>                                                                 | <input checked="" type="checkbox"/> All | <input type="checkbox"/> All            |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All         |
| Emergency Room Services                                                        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| All Inpatient Hospital Services (inc. MH/SUD)                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays) | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Specialist Visit                                                               | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$60.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Mental/Behavioral Health and Substance Use Disorder Outpatient Services        | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Imaging (CT/PET Scans, MRIs)                                                   | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Speech Therapy                                                                 | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Occupational and Physical Therapy                                              | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Preventive Care/Screening/Immunization                                         | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Laboratory Outpatient and Professional Services                                | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| X-rays and Diagnostic Imaging                                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Skilled Nursing Facility                                                       | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Outpatient Surgery Physician/Surgical Services                                 | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| <b>Drugs</b>                                                                   | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All         |
| Generics                                                                       | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$25.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Preferred Brand Drugs                                                          | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$50.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Non-Preferred Brand Drugs                                                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Specialty Drugs (i.e. high-cost)                                               | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     | 50%                       |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |

**Options for Additional Benefit Design Limits:**

|                                                                         |                                     |
|-------------------------------------------------------------------------|-------------------------------------|
| Set a Maximum on Specialty Rx Coinsurance Payments?                     | <input type="checkbox"/>            |
| Specialty Rx Coinsurance Maximum:                                       |                                     |
| Set a Maximum Number of Days for Charging an IP Copay?                  | <input type="checkbox"/>            |
| # Days (1-10):                                                          |                                     |
| Begin Primary Care Cost-Sharing After a Set Number of Visits?           | <input checked="" type="checkbox"/> |
| # Visits (1-10):                                                        | 1                                   |
| Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? | <input type="checkbox"/>            |
| # Copays (1-10):                                                        |                                     |

**Plan Description:**  
 Name:  
 Plan HIOS ID:  
 Issuer HIOS ID:  
 AVC Version: 2027\_1b

**Output**

Status/Error Messages: CSR Level of 94% (100-150% FPL), Calculation Successful.  
 Actuarial Value: 94.57%  
 Metal Tier: Platinum  
 NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Additional Notes:

Calculation Time: 0.0469 seconds

**Final 2027 AV Calculator**

# CLEAR CHOICE: SILVER \$4,500

## 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? <input type="checkbox"/> | Tiered Network Plan? <input type="checkbox"/>  |
| Annual Contribution Amount:                             | 1st Tier Utilization:<br>2nd Tier Utilization: |

| Tier 1 Plan Benefit Design             |      |             |
|----------------------------------------|------|-------------|
| Medical                                | Drug | Combined    |
| Deductible (\$)                        |      | \$4,500.00  |
| Coinsurance (% , Insurer's Cost Share) |      | 70.00%      |
| MOOP (\$)                              |      | \$10,000.00 |
| MOOP if Separate (\$)                  |      |             |

| Tier 2 Plan Benefit Design             |      |          |
|----------------------------------------|------|----------|
| Medical                                | Drug | Combined |
| Deductible (\$)                        |      |          |
| Coinsurance (% , Insurer's Cost Share) |      |          |
| MOOP (\$)                              |      |          |
| MOOP if Separate (\$)                  |      |          |

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| Type of Benefit                                                                | Tier 1                                  |                                         |                           |                    | Tier 2                                  |                                         |                           |                    | Tier 1                               | Tier 2                       |
|--------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|--------------------------------------|------------------------------|
|                                                                                | 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? |                              |
| <b>Medical</b>                                                                 | <input checked="" type="checkbox"/> All | <input type="checkbox"/> All            |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All |
| Emergency Room Services                                                        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| All Inpatient Hospital Services (inc. MH/SUD)                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays) | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Specialist Visit                                                               | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$60.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Mental/Behavioral Health and Substance Use Disorder Outpatient Services        | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Imaging (CT/PET Scans, MRIs)                                                   | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Speech Therapy                                                                 | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Occupational and Physical Therapy                                              | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Preventive Care/Screening/Immunization                                         | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Laboratory Outpatient and Professional Services                                | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| X-rays and Diagnostic Imaging                                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Skilled Nursing Facility                                                       | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Outpatient Surgery Physician/Surgical Services                                 | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| <b>Drugs</b>                                                                   | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All |
| Generics                                                                       | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$25.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Preferred Brand Drugs                                                          | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$50.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Non-Preferred Brand Drugs                                                      | <input checked="" type="checkbox"/>     | <input type="checkbox"/>                |                           | \$100.00           | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>  | <input type="checkbox"/>     |
| Specialty Drugs (i.e. high-cost)                                               | <input checked="" type="checkbox"/>     | <input type="checkbox"/>                |                           | \$250.00           | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>  | <input type="checkbox"/>     |

### Options for Additional Benefit Design Limits:

|                                                                         |                                     |
|-------------------------------------------------------------------------|-------------------------------------|
| Set a Maximum on Specialty Rx Coinsurance Payments?                     | <input type="checkbox"/>            |
| Specialty Rx Coinsurance Maximum:                                       |                                     |
| Set a Maximum Number of Days for Charging an IP Copay?                  | <input type="checkbox"/>            |
| # Days (1-10):                                                          |                                     |
| Begin Primary Care Cost-Sharing After a Set Number of Visits?           | <input checked="" type="checkbox"/> |
| # Visits (1-10):                                                        | 1                                   |
| Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? | <input type="checkbox"/>            |
| # Copays (1-10):                                                        |                                     |

### Plan Description:

Name:  
Plan HIOS ID:  
Issuer HIOS ID:  
AVC Version: 2027\_1b

### Output

Calculate

Status/Error Messages:

Calculation Successful.

Actuarial Value:

71.48%

Metal Tier:

Silver

NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Additional Notes:

Calculation Time:

0.0371 seconds

Final 2027 AV Calculator

# CLEAR CHOICE: SILVER \$4,500 CSR 73%

## 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? <input type="checkbox"/> | Tiered Network Plan? <input type="checkbox"/>  |
| Annual Contribution Amount:                             | 1st Tier Utilization:<br>2nd Tier Utilization: |

|                                        | Tier 1 Plan Benefit Design |      |            | Tier 2 Plan Benefit Design |      |          |
|----------------------------------------|----------------------------|------|------------|----------------------------|------|----------|
|                                        | Medical                    | Drug | Combined   | Medical                    | Drug | Combined |
| Deductible (\$)                        |                            |      | \$3,600.00 |                            |      |          |
| Coinsurance (% , Insurer's Cost Share) |                            |      | 70.00%     |                            |      |          |
| MOOP (\$)                              |                            |      | \$8,500.00 |                            |      |          |
| MOOP if Separate (\$)                  |                            |      |            |                            |      |          |

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| Type of Benefit                                                                | Tier 1                                  |                                     |                           |                    | Tier 2                                  |                                         |                           |                    | Tier 1                               | Tier 2                       |
|--------------------------------------------------------------------------------|-----------------------------------------|-------------------------------------|---------------------------|--------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|--------------------------------------|------------------------------|
|                                                                                | 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? |                              |
| <b>Medical</b>                                                                 | <input checked="" type="checkbox"/> All | <input type="checkbox"/> All        |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All |
| Emergency Room Services                                                        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/> |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| All Inpatient Hospital Services (inc. MH/SUD)                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/> |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays) | <input type="checkbox"/>                | <input type="checkbox"/>            |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Specialist Visit                                                               | <input type="checkbox"/>                | <input type="checkbox"/>            |                           | \$60.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Mental/Behavioral Health and Substance Use Disorder Outpatient Services        | <input type="checkbox"/>                | <input type="checkbox"/>            |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Imaging (CT/PET Scans, MRIs)                                                   | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/> |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Speech Therapy                                                                 | <input type="checkbox"/>                | <input type="checkbox"/>            |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Occupational and Physical Therapy                                              | <input type="checkbox"/>                | <input type="checkbox"/>            |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Preventive Care/Screening/Immunization                                         | <input type="checkbox"/>                | <input type="checkbox"/>            | 100%                      | \$0.00             | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Laboratory Outpatient and Professional Services                                | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/> |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| X-rays and Diagnostic Imaging                                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/> |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Skilled Nursing Facility                                                       | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/> |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/> |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Outpatient Surgery Physician/Surgical Services                                 | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/> |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| <b>Drugs</b>                                                                   | <input checked="" type="checkbox"/> All | <input type="checkbox"/> All        |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All |
| Generics                                                                       | <input type="checkbox"/>                | <input type="checkbox"/>            |                           | \$25.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Preferred Brand Drugs                                                          | <input type="checkbox"/>                | <input type="checkbox"/>            |                           | \$50.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Non-Preferred Brand Drugs                                                      | <input checked="" type="checkbox"/>     | <input type="checkbox"/>            |                           | \$100.00           | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>  | <input type="checkbox"/>     |
| Specialty Drugs (i.e. high-cost)                                               | <input checked="" type="checkbox"/>     | <input type="checkbox"/>            |                           | \$250.00           | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>  | <input type="checkbox"/>     |

### Options for Additional Benefit Design Limits:

|                                                                         |                                     |
|-------------------------------------------------------------------------|-------------------------------------|
| Set a Maximum on Specialty Rx Coinsurance Payments?                     | <input type="checkbox"/>            |
| Specialty Rx Coinsurance Maximum:                                       |                                     |
| Set a Maximum Number of Days for Charging an IP Copay?                  | <input type="checkbox"/>            |
| # Days (1-10):                                                          |                                     |
| Begin Primary Care Cost-Sharing After a Set Number of Visits?           | <input checked="" type="checkbox"/> |
| # Visits (1-10):                                                        | 1                                   |
| Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? | <input type="checkbox"/>            |
| # Copays (1-10):                                                        |                                     |

### Plan Description:

Name:  
Plan HIOS ID:  
Issuer HIOS ID:  
AVC Version: 2027\_1b

### Output

Calculate

Status/Error Messages:

CSR Level of 73% (200-250% FPL), Calculation Successful.

Actuarial Value:

73.53%

Metal Tier:

Silver

NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Additional Notes:

Calculation Time:

0.0469 seconds

Final 2027 AV Calculator

# CLEAR CHOICE: SILVER \$4,500 CSR 87%

## 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?

| HSA/HRA Options                                         | Tiered Network Option                         |
|---------------------------------------------------------|-----------------------------------------------|
| HSA/HRA Employer Contribution? <input type="checkbox"/> | Tiered Network Plan? <input type="checkbox"/> |
| Annual Contribution Amount:                             | 1st Tier Utilization:                         |
|                                                         | 2nd Tier Utilization:                         |

Desired Metal Tier: Gold

|                                        | Tier 1 Plan Benefit Design |      |            | Tier 2 Plan Benefit Design |      |          |
|----------------------------------------|----------------------------|------|------------|----------------------------|------|----------|
|                                        | Medical                    | Drug | Combined   | Medical                    | Drug | Combined |
| Deductible (\$)                        |                            |      | \$800.00   |                            |      |          |
| Coinsurance (% , Insurer's Cost Share) |                            |      | 70.00%     |                            |      |          |
| MOOP (\$)                              |                            |      | \$2,500.00 |                            |      |          |
| MOOP if Separate (\$)                  |                            |      |            |                            |      |          |

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| Type of Benefit                                                                | Tier 1                                  |                                         |                           |                    | Tier 2                                  |                                         |                           |                    | Tier 1                               | Tier 2                       |
|--------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|--------------------------------------|------------------------------|
|                                                                                | 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? |                              |
| <b>Medical</b>                                                                 | <input checked="" type="checkbox"/> All | <input type="checkbox"/> All            |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All |
| Emergency Room Services                                                        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| All Inpatient Hospital Services (inc. MH/SUD)                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays) | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Specialist Visit                                                               | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$60.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Mental/Behavioral Health and Substance Use Disorder Outpatient Services        | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Imaging (CT/PET Scans, MRIs)                                                   | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Speech Therapy                                                                 | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Occupational and Physical Therapy                                              | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Preventive Care/Screening/Immunization                                         | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Laboratory Outpatient and Professional Services                                | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| X-rays and Diagnostic Imaging                                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Skilled Nursing Facility                                                       | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Outpatient Surgery Physician/Surgical Services                                 | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| <b>Drugs</b>                                                                   | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All |
| Generics                                                                       | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$25.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Preferred Brand Drugs                                                          | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$50.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Non-Preferred Brand Drugs                                                      | <input checked="" type="checkbox"/>     | <input type="checkbox"/>                |                           | \$100.00           | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>  | <input type="checkbox"/>     |
| Specialty Drugs (i.e. high-cost)                                               | <input checked="" type="checkbox"/>     | <input type="checkbox"/>                |                           | \$250.00           | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>  | <input type="checkbox"/>     |

### Options for Additional Benefit Design Limits:

|                                                                         |                                     |
|-------------------------------------------------------------------------|-------------------------------------|
| Set a Maximum on Specialty Rx Coinsurance Payments?                     | <input type="checkbox"/>            |
| Specialty Rx Coinsurance Maximum:                                       |                                     |
| Set a Maximum Number of Days for Charging an IP Copay?                  | <input type="checkbox"/>            |
| # Days (1-10):                                                          |                                     |
| Begin Primary Care Cost-Sharing After a Set Number of Visits?           | <input checked="" type="checkbox"/> |
| # Visits (1-10):                                                        | 1                                   |
| Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? | <input type="checkbox"/>            |
| # Copays (1-10):                                                        |                                     |

### Plan Description:

Name:  
 Plan HIOS ID:  
 Issuer HIOS ID:  
 AVC Version: 2027\_1b

### Output

Calculate

Status/Error Messages: CSR Level of 87% (150-200% FPL), Calculation Successful.  
 Actuarial Value: 87.06%  
 Metal Tier: Gold  
 NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Additional Notes:

Calculation Time: 0.0469 seconds

Final 2027 AV Calculator

# CLEAR CHOICE: SILVER \$4,500 CSR 94%

## 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? <input type="checkbox"/> | Tiered Network Plan? <input type="checkbox"/> |
| Annual Contribution Amount:                             | 1st Tier Utilization:                         |
|                                                         | 2nd Tier Utilization:                         |

| Tier 1 Plan Benefit Design |      |            |
|----------------------------|------|------------|
| Medical                    | Drug | Combined   |
|                            |      | \$400.00   |
|                            |      | 75.00%     |
|                            |      | \$1,300.00 |
|                            |      |            |
|                            |      |            |

| Tier 2 Plan Benefit Design |      |          |
|----------------------------|------|----------|
| Medical                    | Drug | Combined |
|                            |      |          |
|                            |      |          |
|                            |      |          |
|                            |      |          |
|                            |      |          |

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| Type of Benefit                                                                | Tier 1                                  |                                         |                           |                    | Tier 2                                  |                                         |                           |                    | Tier 1                               | Tier 2                       |
|--------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|--------------------------------------|------------------------------|
|                                                                                | 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? |                              |
| <b>Medical</b>                                                                 | <input checked="" type="checkbox"/> All | <input type="checkbox"/> All            |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All |
| Emergency Room Services                                                        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| All Inpatient Hospital Services (inc. MH/SUD)                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays) | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Specialist Visit                                                               | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$60.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Mental/Behavioral Health and Substance Use Disorder Outpatient Services        | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Imaging (CT/PET Scans, MRIs)                                                   | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Speech Therapy                                                                 | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Occupational and Physical Therapy                                              | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Preventive Care/Screening/Immunization                                         | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Laboratory Outpatient and Professional Services                                | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| X-rays and Diagnostic Imaging                                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Skilled Nursing Facility                                                       | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Outpatient Surgery Physician/Surgical Services                                 | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| <b>Drugs</b>                                                                   | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All |
| Generics                                                                       | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$25.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Preferred Brand Drugs                                                          | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$50.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Non-Preferred Brand Drugs                                                      | <input checked="" type="checkbox"/>     | <input type="checkbox"/>                |                           | \$100.00           | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>  | <input type="checkbox"/>     |
| Specialty Drugs (i.e. high-cost)                                               | <input checked="" type="checkbox"/>     | <input type="checkbox"/>                |                           | \$250.00           | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>  | <input type="checkbox"/>     |

## Options for Additional Benefit Design Limits:

|                                                                         |                                     |
|-------------------------------------------------------------------------|-------------------------------------|
| Set a Maximum on Specialty Rx Coinsurance Payments?                     | <input type="checkbox"/>            |
| Specialty Rx Coinsurance Maximum:                                       |                                     |
| Set a Maximum Number of Days for Charging an IP Copay?                  | <input type="checkbox"/>            |
| # Days (1-10):                                                          |                                     |
| Begin Primary Care Cost-Sharing After a Set Number of Visits?           | <input checked="" type="checkbox"/> |
| # Visits (1-10):                                                        | 1                                   |
| Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? | <input type="checkbox"/>            |
| # Copays (1-10):                                                        |                                     |

## Plan Description:

Name:  
 Plan HIOS ID:  
 Issuer HIOS ID:  
 AVC Version: 2027\_1b

## Output

Calculate

Status/Error Messages:

CSR Level of 94% (100-150% FPL), Calculation Successful.

Actuarial Value:

94.28%

Metal Tier:

Platinum

NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Additional Notes:

Calculation Time:

0.0508 seconds

Final 2027 AV Calculator

# CLEAR CHOICE: SILVER \$5,000 HSA

**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? | <input type="checkbox"/> |  | Tiered Network Plan?  | <input type="checkbox"/> |
| Annual Contribution Amount:    |                          |  | 1st Tier Utilization: |                          |
|                                |                          |  | 2nd Tier Utilization: |                          |

| Tier 1 Plan Benefit Design             |      |            | Tier 2 Plan Benefit Design |      |          |
|----------------------------------------|------|------------|----------------------------|------|----------|
| Medical                                | Drug | Combined   | Medical                    | Drug | Combined |
| Deductible (\$)                        |      | \$5,000.00 |                            |      |          |
| Coinsurance (% , Insurer's Cost Share) |      | 80.00%     |                            |      |          |
| MOOP (\$)                              |      | \$8,700.00 |                            |      |          |
| MOOP if Separate (\$)                  |      |            |                            |      |          |

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| Type of Benefit                                                                | Tier 1                                  |                                         |                           |                    | Tier 2                                  |                                         |                           |                    | Tier 1                               | Tier 2                               |
|--------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|--------------------------------------|--------------------------------------|
|                                                                                | 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? | Copay applies only after deductible? |
| <b>Medical</b>                                                                 | <input checked="" type="checkbox"/> All | <input type="checkbox"/> All            |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All         |
| Emergency Room Services                                                        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| All Inpatient Hospital Services (inc. MH/SUD)                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays) | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Specialist Visit                                                               | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Mental/Behavioral Health and Substance Use Disorder Outpatient Services        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Imaging (CT/PET Scans, MRIs)                                                   | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Speech Therapy                                                                 | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Occupational and Physical Therapy                                              | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Preventive Care/Screening/Immunization                                         | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Laboratory Outpatient and Professional Services                                | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| X-rays and Diagnostic Imaging                                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Skilled Nursing Facility                                                       | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Outpatient Surgery Physician/Surgical Services                                 | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| <b>Drugs</b>                                                                   | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All         |
| Generics                                                                       | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Preferred Brand Drugs                                                          | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Non-Preferred Brand Drugs                                                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Specialty Drugs (i.e. high-cost)                                               | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |

**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:** \_\_\_\_\_  
**Plan HIOS ID:** \_\_\_\_\_  
**Issuer HIOS ID:** \_\_\_\_\_  
**AVC Version:** 2027\_1b

**Output**

Calculate

Status/Error Messages: Standard On-Exchange Individual Silver Plans must meet a [0, +2] percent de minimis range; Calculation Successful.

Actuarial Value: 68.61%

Metal Tier: Silver Off-Exchange and Small Group Market

Additional Notes:

Calculation Time: 0.043 seconds

**Final 2027 AV Calculator**

# CLEAR CHOICE: GOLD \$2,000

## 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? <input type="checkbox"/> | Tiered Network Plan? <input type="checkbox"/>  |
| Annual Contribution Amount:                             | 1st Tier Utilization:<br>2nd Tier Utilization: |

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

| Tier 2 Plan Benefit Design           |      |          |
|--------------------------------------|------|----------|
| Medical                              | Drug | Combined |
| Deductible (\$)                      |      |          |
| Coinsurance (% Insurer's Cost Share) |      |          |
| MOOP (\$)                            |      |          |
| MOOP if Separate (\$)                |      |          |

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| Type of Benefit                                                                | Tier 1                                  |                                         |                           |                    | Tier 2                                  |                                         |                           |                    | Tier 1                               | Tier 2                               |
|--------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|--------------------------------------|--------------------------------------|
|                                                                                | 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? | Copay applies only after deductible? |
| <b>Medical</b>                                                                 | <input checked="" type="checkbox"/> All | <input type="checkbox"/> All            |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All         |
| Emergency Room Services                                                        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| All Inpatient Hospital Services (inc. MH/SUD)                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays) | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$25.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Specialist Visit                                                               | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$50.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Mental/Behavioral Health and Substance Use Disorder Outpatient Services        | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$25.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Imaging (CT/PET Scans, MRIs)                                                   | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Speech Therapy                                                                 | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$30.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Occupational and Physical Therapy                                              | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$30.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Preventive Care/Screening/Immunization                                         | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Laboratory Outpatient and Professional Services                                | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| X-rays and Diagnostic Imaging                                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Skilled Nursing Facility                                                       | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Outpatient Surgery Physician/Surgical Services                                 | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| <b>Drugs</b>                                                                   | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All         |
| Generics                                                                       | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$25.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Preferred Brand Drugs                                                          | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$50.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Non-Preferred Brand Drugs                                                      | <input checked="" type="checkbox"/>     | <input type="checkbox"/>                |                           | \$80.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>  | <input type="checkbox"/>             |
| Specialty Drugs (i.e. high-cost)                                               | <input checked="" type="checkbox"/>     | <input type="checkbox"/>                |                           | \$250.00           | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>  | <input type="checkbox"/>             |

### Options for Additional Benefit Design Limits:

|                                                                         |                                     |
|-------------------------------------------------------------------------|-------------------------------------|
| Set a Maximum on Specialty Rx Coinsurance Payments?                     | <input type="checkbox"/>            |
| Specialty Rx Coinsurance Maximum:                                       |                                     |
| Set a Maximum Number of Days for Charging an IP Copay?                  | <input type="checkbox"/>            |
| # Days (1-10):                                                          |                                     |
| Begin Primary Care Cost-Sharing After a Set Number of Visits?           | <input checked="" type="checkbox"/> |
| # Visits (1-10):                                                        | 1                                   |
| Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? | <input type="checkbox"/>            |
| # Copays (1-10):                                                        |                                     |

### Plan Description:

Name:  
 Plan HIOS ID:  
 Issuer HIOS ID:  
 AVC Version: 2027\_1b

### Output

Calculate

Status/Error Messages: Calculation Successful.  
 Actuarial Value: 80.13%  
 Metal Tier: Gold  
 NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Additional Notes:

Calculation Time: 0.043 seconds

Final 2027 AV Calculator

# CLEAR CHOICE: GOLD \$3,000 \$25 GENERIC RX COPAY

**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? | <input type="checkbox"/> | Tiered Network Plan?  | <input type="checkbox"/> |
| Annual Contribution Amount:    |                          | 1st Tier Utilization: |                          |
|                                |                          | 2nd Tier Utilization: |                          |

|                                      | Tier 1 Plan Benefit Design |      |            | Tier 2 Plan Benefit Design |      |          |
|--------------------------------------|----------------------------|------|------------|----------------------------|------|----------|
|                                      | Medical                    | Drug | Combined   | Medical                    | Drug | Combined |
| Deductible (\$)                      |                            |      | \$3,000.00 |                            |      |          |
| Coinsurance (% Insurer's Cost Share) |                            |      | 70.00%     |                            |      |          |
| MOOP (\$)                            |                            |      | \$6,000.00 |                            |      |          |
| MOOP if Separate (\$)                |                            |      |            |                            |      |          |

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| Type of Benefit                                                                | Tier 1                                  |                                         |                           |                    | Tier 2                                  |                                         |                           |                    | Tier 1                               | Tier 2                               |
|--------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|--------------------------------------|--------------------------------------|
|                                                                                | 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? | Copay applies only after deductible? |
| <b>Medical</b>                                                                 | <input checked="" type="checkbox"/> All | <input type="checkbox"/> All            |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All         |
| Emergency Room Services                                                        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| All Inpatient Hospital Services (inc. MH/SUD)                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays) | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$20.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Specialist Visit                                                               | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$50.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Mental/Behavioral Health and Substance Use Disorder Outpatient Services        | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$20.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Imaging (CT/PET Scans, MRIs)                                                   | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Speech Therapy                                                                 | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$30.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Occupational and Physical Therapy                                              | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$30.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Preventive Care/Screening/Immunization                                         | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Laboratory Outpatient and Professional Services                                | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| X-rays and Diagnostic Imaging                                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Skilled Nursing Facility                                                       | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Outpatient Surgery Physician/Surgical Services                                 | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| <b>Drugs</b>                                                                   | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All         |
| Generics                                                                       | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$25.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Preferred Brand Drugs                                                          | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$50.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Non-Preferred Brand Drugs                                                      | <input type="checkbox"/>                | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |
| Specialty Drugs (i.e. high-cost)                                               | <input type="checkbox"/>                | <input checked="" type="checkbox"/>     | 50%                       |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>             |

**Options for Additional Benefit Design Limits:**

|                                                                         |                                     |
|-------------------------------------------------------------------------|-------------------------------------|
| Set a Maximum on Specialty Rx Coinsurance Payments?                     | <input type="checkbox"/>            |
| Specialty Rx Coinsurance Maximum:                                       |                                     |
| Set a Maximum Number of Days for Charging an IP Copay?                  | <input type="checkbox"/>            |
| # Days (1-10):                                                          |                                     |
| Begin Primary Care Cost-Sharing After a Set Number of Visits?           | <input checked="" type="checkbox"/> |
| # Visits (1-10):                                                        | 1                                   |
| Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? | <input type="checkbox"/>            |
| # Copays (1-10):                                                        |                                     |

**Plan Description:**  
 Name:  
 Plan HIOS ID:  
 Issuer HIOS ID:  
 AVC Version: 2027\_1b

**Output**

Calculate

Status/Error Messages: Calculation Successful.  
 Actuarial Value: 79.89%  
 Metal Tier: Gold  
 NOTE: One or more services are not subject to the deductible and have no copay. Any service with this cost-sharing structure is covered at 100% by the plan in the deductible range. NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Additional Notes:

Calculation Time: 0.043 seconds  
**Final 2027 AV Calculator**

# CLEAR CHOICE: GOLD \$3,000 \$10 GENERIC RX COPAY

## 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? <input type="checkbox"/> | Tiered Network Plan? <input type="checkbox"/> |
| Annual Contribution Amount:                             | 1st Tier Utilization:                         |
|                                                         | 2nd Tier Utilization:                         |

|                                      | Tier 1 Plan Benefit Design |      |            | Tier 2 Plan Benefit Design |      |          |
|--------------------------------------|----------------------------|------|------------|----------------------------|------|----------|
|                                      | Medical                    | Drug | Combined   | Medical                    | Drug | Combined |
| Deductible (\$)                      |                            |      | \$3,000.00 |                            |      |          |
| Coinsurance (% Insurer's Cost Share) |                            |      | 70.00%     |                            |      |          |
| MOOP (\$)                            |                            |      | \$6,000.00 |                            |      |          |
| MOOP if Separate (\$)                |                            |      |            |                            |      |          |

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| Type of Benefit                                                                | Tier 1                                  |                                         |                           |                    | Tier 2                                  |                                         |                           |                    | Tier 1                               | Tier 2                       |
|--------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|--------------------------------------|------------------------------|
|                                                                                | 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? |                              |
| <b>Medical</b>                                                                 | <input checked="" type="checkbox"/> All | <input type="checkbox"/> All            |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All |
| Emergency Room Services                                                        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| All Inpatient Hospital Services (inc. MH/SUD)                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays) | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$20.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Specialist Visit                                                               | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$50.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Mental/Behavioral Health and Substance Use Disorder Outpatient Services        | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$20.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Imaging (CT/PET Scans, MRIs)                                                   | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Speech Therapy                                                                 | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$30.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Occupational and Physical Therapy                                              | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$30.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Preventive Care/Screening/Immunization                                         | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Laboratory Outpatient and Professional Services                                | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| X-rays and Diagnostic Imaging                                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Skilled Nursing Facility                                                       | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Outpatient Surgery Physician/Surgical Services                                 | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| <b>Drugs</b>                                                                   | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All |
| Generics                                                                       | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$10.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Preferred Brand Drugs                                                          | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$50.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Non-Preferred Brand Drugs                                                      | <input type="checkbox"/>                | <input type="checkbox"/>                |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Specialty Drugs (i.e. high-cost)                                               | <input type="checkbox"/>                | <input checked="" type="checkbox"/>     | 50%                       |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |

### Options for Additional Benefit Design Limits:

|                                                                         |                                     |
|-------------------------------------------------------------------------|-------------------------------------|
| Set a Maximum on Specialty Rx Coinsurance Payments?                     | <input type="checkbox"/>            |
| Specialty Rx Coinsurance Maximum:                                       |                                     |
| Set a Maximum Number of Days for Charging an IP Copay?                  | <input type="checkbox"/>            |
| # Days (1-10):                                                          |                                     |
| Begin Primary Care Cost-Sharing After a Set Number of Visits?           | <input checked="" type="checkbox"/> |
| # Visits (1-10):                                                        | 1                                   |
| Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? | <input type="checkbox"/>            |
| # Copays (1-10):                                                        |                                     |

### Plan Description:

Name:  
 Plan HIOS ID:  
 Issuer HIOS ID:  
 AVC Version: 2027\_1b

### Output

Status/Error Messages:

Calculation Successful.

Actuarial Value:

81.13%

Metal Tier:

Gold

Additional Notes:

NOTE: One or more services are not subject to the deductible and have no copay. Any service with this cost-sharing structure is covered at 100% by the plan in the deductible range. NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Calculation Time:

0.043 seconds

Final 2027 AV Calculator

# CLEAR CHOICE: PLATINUM \$1,000

**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? | <input type="checkbox"/> | Tiered Network Plan?  | <input type="checkbox"/> |
| Annual Contribution Amount:    |                          | 1st Tier Utilization: |                          |
|                                |                          | 2nd Tier Utilization: |                          |

| Tier 1 Plan Benefit Design |      |            | Tier 2 Plan Benefit Design |      |          |
|----------------------------|------|------------|----------------------------|------|----------|
| Medical                    | Drug | Combined   | Medical                    | Drug | Combined |
|                            |      | \$1,000.00 |                            |      |          |
|                            |      | 80.00%     |                            |      |          |
|                            |      | \$4,000.00 |                            |      |          |
|                            |      |            |                            |      |          |

[Click Here for Important Instructions](#)

| Type of Benefit                                                                | Tier 1                                  |                                         |                           |                    | Tier 2                                  |                                         |                           |                    | Tier 1                               | Tier 2                       |
|--------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|-----------------------------------------|-----------------------------------------|---------------------------|--------------------|--------------------------------------|------------------------------|
|                                                                                | 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? |                              |
| <b>Medical</b>                                                                 | <input checked="" type="checkbox"/> All | <input type="checkbox"/> All            |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All |
| Emergency Room Services                                                        | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| All Inpatient Hospital Services (inc. MH/SUD)                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays) | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$20.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Specialist Visit                                                               | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$40.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Mental/Behavioral Health and Substance Use Disorder Outpatient Services        | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$20.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Imaging (CT/PET Scans, MRIs)                                                   | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Speech Therapy                                                                 | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$30.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Occupational and Physical Therapy                                              | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$30.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Preventive Care/Screening/Immunization                                         | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>                | <input type="checkbox"/>                | 100%                      | \$0.00             | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Laboratory Outpatient and Professional Services                                | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| X-rays and Diagnostic Imaging                                                  | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Skilled Nursing Facility                                                       | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center)                      | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Outpatient Surgery Physician/Surgical Services                                 | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| <b>Drugs</b>                                                                   | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input checked="" type="checkbox"/> All | <input checked="" type="checkbox"/> All |                           |                    | <input type="checkbox"/> All         | <input type="checkbox"/> All |
| Generics                                                                       | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$0.00             | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Preferred Brand Drugs                                                          | <input type="checkbox"/>                | <input type="checkbox"/>                |                           | \$15.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input type="checkbox"/>             | <input type="checkbox"/>     |
| Non-Preferred Brand Drugs                                                      | <input checked="" type="checkbox"/>     | <input type="checkbox"/>                |                           | \$80.00            | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>  | <input type="checkbox"/>     |
| Specialty Drugs (i.e. high-cost)                                               | <input checked="" type="checkbox"/>     | <input type="checkbox"/>                |                           | \$250.00           | <input checked="" type="checkbox"/>     | <input checked="" type="checkbox"/>     |                           |                    | <input checked="" type="checkbox"/>  | <input type="checkbox"/>     |

**Options for Additional Benefit Design Limits:**

|                                                                         |                                     |
|-------------------------------------------------------------------------|-------------------------------------|
| Set a Maximum on Specialty Rx Coinsurance Payments?                     | <input type="checkbox"/>            |
| Specialty Rx Coinsurance Maximum:                                       |                                     |
| Set a Maximum Number of Days for Charging an IP Copay?                  | <input type="checkbox"/>            |
| # Days (1-10):                                                          |                                     |
| Begin Primary Care Cost-Sharing After a Set Number of Visits?           | <input checked="" type="checkbox"/> |
| # Visits (1-10):                                                        | 1                                   |
| Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? | <input type="checkbox"/>            |
| # Copays (1-10):                                                        |                                     |

**Plan Description:**  
 Name:  
 Plan HIOS ID:  
 Issuer HIOS ID:  
 AVC Version: 2027\_1b

**Output**

Calculate

Status/Error Messages: Calculation Successful.  
 Actuarial Value: 90.31%  
 Metal Tier: Platinum  
 NOTE: Office-visit-specific cost-sharing is applying to x-rays in office settings.

Additional Notes:

Calculation Time: 0.0469 seconds  
**Final 2027 AV Calculator**