

# Chapter 11: Actuarial Value Calculator

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## Overview

To satisfy actuarial value (AV) requirements (45 CFR 156.140 and 156.420), QHP issuers are required to use the Actuarial Value Calculator (AVC) developed and made available by HHS unless the plan design is not compatible with the AVC (a unique plan design) (45 CFR 156.135). In order to assist with this calculation, the Plans & Benefits Template facilitates an automated AV calculation using the AVC and the data entered into the Template. In addition, upon submission of a QHP Application, HHS recalculates this value to validate that an issuer's plan designs meet AV requirements.

Issuers are encouraged to assess the AV of a given plan design by first using the stand-alone AVC. After completion of the Plans & Benefits Template, the AV obtained from the Template should be identical to the value obtained via the stand-alone AVC. If it is not, issuers should first ensure that they filled out this Template correctly per the instructions in this chapter. If issuers are still unable to obtain an AV from the Plans and Benefits Template that matches what they obtain via the stand-alone AVC, then they should designate that particular plan as a unique plan design using the *Unique Plan Design?* field of the Benefits Package worksheet. For this plan, the issuer should then complete the *Issuer Actuarial Value* data field with the value from the stand-alone AVC. The issuer should also upload a screen shot of the stand-alone AVC with that value as a supporting document for each plan for which this situation occurs. They should indicate the *HIOS Plan ID (Standard Component)* in the Description field when uploading the screen shot as a supporting document in HIOS as well as indicating the *HIOS Plan ID (Standard Component)* in the file name of the screen shot. Please note that in this situation designating your plan as a unique plan design will not require submission of an actuarial certification and you will not be considered unique for review purposes.

## Purpose

This chapter describes how the cost-sharing information from the Plans & Benefits template is translated into inputs for the stand-alone AVC.

## Data Requirements

To calculate AVs on the Plans & Benefits template, you need to do the following:

1. Select the relevant Cost Share Variances worksheet in the Plans & Benefits template and fill out all cost-sharing information necessary to run the AVC.
2. Download the stand-alone AVC, which is available at: <http://cciio.cms.gov/resources/regulations/index.html#pm>. The AVC methodology document, also available at this location, provides further guidance on how to use the stand-alone AVC.

Figure 11-1 identifies some key items to note when calculating AVs from the Plans & Benefits template.

### Figure 11-1. AVC Highlights

- If the plan design is not compatible with the AVC (a unique plan design), the AV from the AVC is not used during validation of the Plans & Benefits template.
- The *Desired Metal Tier* in the AVC is set to **Silver** for the 73 percent silver plan variations, **Gold** for 87 percent silver plan variations, and **Platinum** for 94 percent silver plan variations.
- The AVC will return an error to the Plans & Benefits template when the sum of the medical and drug OOPMs exceeds \$6,500. Small group plans with multiple benefit administrators may, under certain circumstances, have combined medical and drug OOPMs that exceed \$6,500. These small group plans should select **Yes** in the *Unique Plan Design?* field on the Benefits Package worksheet, and fill in the *Issuer Actuarial Value* field on the Cost Share Variances worksheet. These plans designs are incompatible with the AVC and the issuer must submit an actuarial certification among other requirements in accordance with the final rule. (For more details see the discussion on the annual limitation on cost sharing in the “2014 Letter to Issuers on Federally-facilitated and State Partnership Exchanges” at: [http://cciio.cms.gov/resources/regulations/Files/2014\\_letter\\_to\\_issuers\\_04052013.pdf](http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf))
- The *Blended Network/POS Plan* checkbox in the AVC is not related to the *Plan Type* selection in the Plans & Benefits template. Non-POS plans can have multiple in network tiers in the Plans & Benefits template, resulting in the *Blended Network/POS Plan* checkbox being checked in the AVC.
- The *Subject to Deductible (Tier 1)* and *Subject to Deductible (Tier 2)* fields on the Benefits Package worksheet of the Plans & Benefits template determine whether to check the *Tier 1 Subject to Deductible?* or *Tier 2 Subject to Deductible?* checkboxes in the AVC. Coinsurance and copay selections (such as **X% after deductible** and **\$X before deductible**) are not considered.
- The Plans & Benefits template uses the term Maximum Out of Pocket (MOOP), while the AVC uses the term Out of Pocket Maximum (OOPM). This document uses OOPM, unless referencing a specific data element from the Plans & Benefits template.
- Individual OOPMs and deductibles from the Plans & Benefits template are used as inputs for the AVC.
- If the in network OOPM or deductible is equal to **Not Applicable** in the Plans & Benefits template, the combined in/out of network OOPM or deductible is used for the AVC.
- While the coinsurance values in the Plans & Benefits template represent the percentage of costs that the enrollee pays for a given service, the coinsurance values in the AVC represent the percentage of costs the issuer pays.

(continued on the next page)

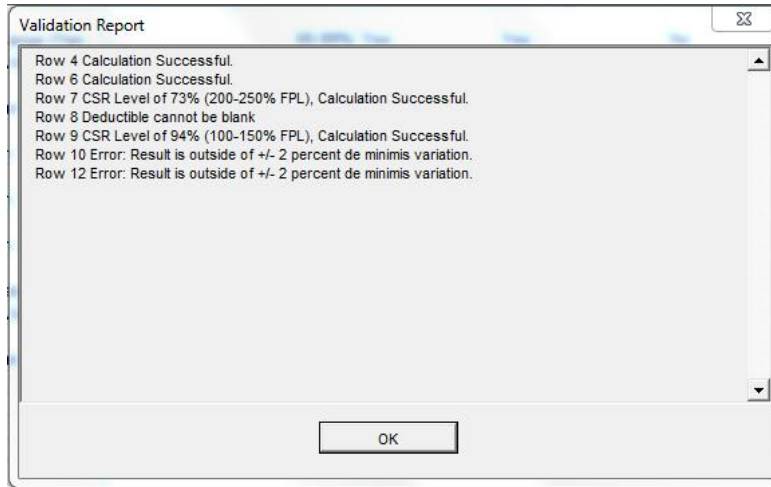
- If a benefit has coinsurance equal to **No Charge** and a copay greater than \$0, the AVC assumes that the enrollee pays a copay until reaching the OOPM. If a benefit has a coinsurance equal to 0% and a copay greater than \$0, the AVC assumes that the enrollee pays a copay until meeting the deductible, and then pays nothing after the deductible.
- For purposes of the AVC, issuers may convert a plan's Outpatient Facility Fee or Outpatient Surgery Physician/Surgical Services copay into an estimated coinsurance.
- The AVC Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services cost-sharing fields are weighted averages of the Mental/Behavioral Health Outpatient Services and the Substance Abuse Disorder Outpatient Services cost-sharing fields in the Plans & Benefits template.
- If a copay and a coinsurance are entered for a drug benefit in the Plans & Benefits template, the AVC will return an error.

### Calculating Actuarial Values

The **Check AV Calc** procedure in the **Plans and Benefits** ribbon tab allows a user to calculate AVs for all applicable plans. The user must first select the relevant Cost Share Variances worksheet and fill out all cost-sharing information necessary to run the AVC. The user then clicks on the **Check AV Calc** button, which prompts the user to select the file location of the stand-alone AVC. After the user identifies the AVC, a procedure auto-populates the AVC for each plan or plan variation and copies resulting AVs into the Plans & Benefits template.

After the procedure is complete, a validation message box, shown in Figure 11-2, appears with the *Status/Error Message* from the AVC for each plan or plan variation. The *AV Calculator Output Number* (column F in the Cost Share Variances worksheet) is also updated with the AV from the AVC (cell B56 in the AVC). If an error prevented an AV from being calculated, the *AV Calculator Output Number* is left blank. Figure 11-3 shows an example of the AV output in the Plans & Benefits template, and Figure 11-4 shows the output section of the AVC.

**Figure 11-2. AVC Validation Report in Plans & Benefits Template**



**Figure 11-3. AV Output in Plans & Benefits Template**

				<i>Cost Sharing Reduction Information</i>	
HIOS Plan ID* (Standard Component + Variant)	Plan Marketing Name*	Level of Coverage* (Metal Level)	CSR Variation Type*	Issuer Actuarial Value	AV Calculator Output Number*
12345AR1234567-01	Silver Test	Silver	Standard Silver On Exchange Plan		69.89%
12345AR1234567-02			Zero Cost Sharing Plan Variation		100.00%
12345AR1234567-03			Limited Cost Sharing Plan Variation		69.89%
12345AR1234567-04		Silver	73% AV Level Silver Plan		72.71%
12345AR1234567-05		Silver	87% AV Level Silver Plan		86.29%
12345AR1234567-06		Silver	94% AV Level Silver Plan		
12345AR1234568-01	Gold Test	Gold	Standard Gold On Exchange Plan		81.85%
12345AR1234568-02			Zero Cost Sharing Plan Variation		100.00%
12345AR1234568-03			Limited Cost Sharing Plan Variation		81.85%

**Figure 11-4. AVC Output**

	A	B
53	<b>Output</b>	
54	<input type="button" value="Calculate"/>	
55	Status/Error Messages:	Calculation Successful.
56	Actuarial Value:	69.9%
57	Metal Tier:	Silver
58		

If any changes are made to the Plans & Benefits template after running the **Check AV Calc** procedure, the user will need to rerun the procedure so that the AVs in the *AV Calculator Output Number* field are updated to reflect the changes. While users can use the stand-alone AVC to test plan designs, issuers do not submit a completed stand-alone AVC; instead, issuers submit a completed Plans & Benefits template that includes the AVs populated by the **Check AV Calc** procedure.

## Plans Using the AVC

The Plans & Benefits template will use the AVC to calculate AVs for all standard, non-catastrophic plans, all silver plan CSR variations, and all limited cost sharing plan variations. Even if the plan design is not compatible with the AVC (a unique plan design), users should click on the **Check AV Calc** button and attempt to calculate AVs using the AVC. If AVs cannot be calculated, the *AV Calculator Output Number* will remain blank. If *Unique Plan Design?* equals **Yes** on the Benefits Package worksheet of the Plans & Benefits template, the AV from the AVC is not used during validation; instead, the *Issuer Actuarial Value* entered by the issuer into the Cost Share Variances worksheet is used to validate that the plan's AV is within the relevant de minimis range.

A de minimis variation of +/-2 percentage points is used for standard plans, while +/-1 percentage point is used for silver plan CSR variations. More detail on zero cost sharing and limited cost sharing plan variations can be found at the end of this chapter.

Issuers are encouraged to assess the AV of a given plan design by first using the stand-alone AVC. After completion of the Plans & Benefits Template, the AV obtained from the Template should be identical to the value obtained via the stand-alone AVC. If it is not, issuers should first ensure that they filled out this Template correctly per the instructions in this chapter. If issuers are still unable to obtain an AV from the Plans and Benefits Template that matches what they obtain via the stand-alone AVC, then they should designate that particular plan as a unique plan design using the *Unique Plan Design?* field of the Benefits Package worksheet. For this plan, the issuer should then complete the *Issuer Actuarial Value* data field with the value from the stand-alone AVC. The issuer should also upload a screen shot of the stand-alone AVC with that value as a supporting document for each plan for which this situation occurs. They should indicate the *HIOS Plan ID (Standard Component)* in the Description field when uploading the screen shot as a supporting document in HIOS as well as indicating the *HIOS Plan ID (Standard Component)* in the file name of the screen shot. Please note that in this situation designating your plan as a unique plan design will not require submission of an actuarial certification and you will not be considered unique for review purposes.

## Field Mapping

This section describes how the **Check AV Calc** procedure maps data from the Plans & Benefit template into the AVC. These mappings take place automatically and do not need to be performed by the user. If any of the required data fields in the Plans & Benefits template are blank or contain invalid values, the procedure will return an error.

The data fields described below are generally listed in the order that a user would likely see them when completing the Plans & Benefits template, starting with the Benefits Package worksheet and followed by the Cost Share Variances worksheet.

### Metal Tier

For standard plans, the *Level of Coverage* selected for the plan in the Plans & Benefits template is mapped to the *Desired Metal Tier* in the AVC.

For silver plan CSR variations, the *Indicate if Plan Meets CSR Standard?* checkbox in the AVC is checked. To ensure that the correct continuance table is used for these plans, the *Desired Metal*

*Tier* depends on the AV level of the variation. The *Desired Metal Tier* is set equal to **Silver** for the 73 percent variation, **Gold** for the 87 percent variation, and **Platinum** for the 94 percent variation.

### HSA/HRA Options

If *HSA/HRA Employer Contribution* is equal to **Yes** in the Benefits Package worksheet of the Plans & Benefits template, the *HSA/HRA Employer Contribution?* checkbox in the AVC is checked. The dollar amount entered for the *HSA/HRA Employer Contribution Amount* in the Plans & Benefits template is mapped to the *Annual Contribution Amount* in the AVC. Figure 11-5 shows the HSA/HRA input fields in the Plans & Benefits template, and Figure 11-6 shows the corresponding input fields in the AVC.

**Figure 11-5. HSA/HRA Input Fields in Plans & Benefits Template**

S	T
HSA/HRA Employer Contribution	HSA/HRA Employer Contribution Amount
Yes	\$500.00

**Figure 11-6. HSA/HRA Input Fields in AVC**

HSA/HRA Options	
HSA/HRA Employer Contribution?	<input checked="" type="checkbox"/>
Annual Contribution Amount:	\$500.00

### Narrow Network Options

If *Multiple In Network Tiers?* is equal to **Yes** in the Cost Sharing Variances worksheet of the Plans & Benefits template, the *Blended Network/POS Plan?* checkbox in the AVC is checked. The *1st Tier Utilization* and *2nd Tier Utilization* fields in the Plans & Benefits template are mapped to the *1st Tier Utilization* and *2nd Tier Utilization* fields in the AVC. The Plans & Benefits template requires that all silver plan CSR and limited cost sharing plan variations have the same *1st Tier Utilization* and *2nd Tier Utilization* as the standard plan

The *Blended Network/POS Plan* checkbox in the AVC is not related to the *Plan Type* selection in the Plans & Benefits template. Non-POS plans can have multiple in network tiers in the Plans & Benefits template, resulting in the *Blended Network/POS Plan* checkbox being checked in the AVC.

Figure 11-7 shows the multiple tier input fields in the Plans & Benefits template, and Figure 11-8 shows the corresponding input fields in the AVC.

Figure 11-7. Multiple In Network Tier Options in Plans & Benefits Template

Multiple In Network Tiers? <sup>*</sup>	1st Tier Utilization <sup>*</sup>	2nd Tier Utilization
Yes	80%	20%

Figure 11-8. Multiple Tier Options in AVC

Narrow Network Options	
Blended Network/POS Plan?	<input checked="" type="checkbox"/>
1st Tier Utilization:	80%
2nd Tier Utilization:	20%

### Subject to Deductible?

For each benefit, if *Subject to Deductible (Tier 1)* is equal to **Yes** in the Benefits Package worksheet of the Plans & Benefits template, the *Tier 1 Subject to Deductible?* checkbox for the corresponding benefit in the AVC is checked. If the plan has multiple in network tiers and *Subject to Deductible (Tier 2)* is equal to **Yes** in Benefits Package worksheet of the Plans & Benefits template, the *Tier 2 Subject to Deductible?* checkbox for the corresponding benefit in the AVC is checked.

If a benefit is not covered, the corresponding *Subject to Deductible?* checkboxes in the AVC are checked because the enrollee is responsible for all costs associated with the benefit category during (and after) the deductible phase. Figure 11-9 shows the *Subject to Deductible* fields in the Plans & Benefits template, and Figure 11-10 shows the corresponding *Tier 1 Subject to Deductible?* checkboxes in the AVC.

Figure 11-9. Subject to Deductible Fields in Plans & Benefits Template

	A	B	C	D	E	M	N	O	P
	Benefit Information				Deductible and Out of Pocket Exceptions				
	Benefits	EHB	State Mandate	Is this Benefit Covered?	Subject to Deductible (Tier 1)	Subject to Deductible (Tier 2)	Excluded from In Network MOOP	Excluded from Out of Network MOOP	
59									
60	Primary Care Visit to Treat an Injury or Illness	Yes		Covered	No	No	No	No	
61	Specialist Visit	Yes		Covered	No	No	No	No	
62	Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes		Covered	Yes	Yes	No	No	
63	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes		Covered	Yes	Yes	No	No	
64	Outpatient Surgery Physician/Surgical Services	Yes		Covered	Yes	Yes	No	No	
65									

Figure 11-10. Benefit Categories in AVC

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$20.00
Specialist Visit	<input type="checkbox"/>	<input checked="" type="checkbox"/>	90%	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<b>Drugs</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

The coinsurance and copay drop-down menus in the Plans & Benefits template include options such as **X% after deductible** and **\$X before deductible**. These coinsurance and copay selections are not considered when determining whether to check the *Tier 1 Subject to Deductible?* or *Tier 2 Subject to Deductible?* in the AVC. On the Cost Share Variance tab, issuers are expected to select the coinsurance and copay options that are consistent with what is entered on the Benefits Package tab regarding when the covered benefit is subject to the deductible.

### Out of Pocket Maximum (OOPM) and Deductible Values

The AVC standard population and claims data were developed using claims data that did not include any family cost-sharing information. Therefore, individual OOPMs and deductibles from the Plans & Benefits template are used as inputs for the AVC. (The Plans & Benefits template uses the term Maximum Out of Pocket [MOOP], while the AVC uses the term Out of Pocket Maximum [OOPM]. For the remainder of this document OOPM is used, unless referencing a specific data element from the Plans & Benefits template.)

Because some plans may have only combined in and out of network OOPMs or deductibles, rather than separate in network and out of network OOPMs or deductibles, the following logic determines which OOPMs and deductibles from the Plans & Benefits template are used as inputs for the AVC.



If the plan does not have multiple in network tiers:

- If the *In Network* field is equal to a dollar value (**\$X**), then the *In Network* field is used for the AVC.
- If the *In Network* field is equal to **Not Applicable** and the *Combined In/Out of Network* field is equal to a dollar value, then the *Combined In/Out of Network* field is used for the AVC.
- If the *In Network* and *Combined In/Out of Network* fields are equal to **Not Applicable**, the Plans & Benefits template returns an error when attempting to calculate an AV.

If the plan has multiple in network tiers:

- If the *In Network* and *In Network (Tier 2)* fields are equal to dollar values, then the *In Network* and *In Network (Tier 2)* fields are used for the AVC.
- If the *In Network* and *In Network (Tier 2)* fields are equal to **Not Applicable**, and the *Combined In/Out of Network* field is equal to a dollar value, then the *Combined In/Out of Network* field is used for the AVC. In this case, the *Combined In/Out of Network* OOPM or deductible is mapped to both the Tier 1 and Tier 2 OOPMs or deductibles, respectively, in the AVC.
- The Plans & Benefits template returns an error when attempting to calculate an AV in the following scenarios:
  - The *In Network* field is equal to a dollar value and the *In Network (Tier 2)* field is equal to **Not Applicable**.
  - The *In Network* field is equal to **Not Applicable** and the *In Network (Tier 2)* field is equal to a dollar value.
  - The *In Network*, *In Network (Tier 2)*, and *Combined In/Out of Network* fields are equal to **Not Applicable**.

### Out of Pocket Maximums

If *Medical & Drug Maximum Out of Pocket Integrated?* is equal to **Yes** in the Cost Sharing Variances worksheet of the Plans & Benefits template, the *Use Separate OOP Maximum for Medical and Drug Spending?* checkbox in the AVC is unchecked. In the case of integrated OOPMs:

- The *Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)–In Network–Individual* or *Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)–Combined In/Out Network–Individual* value in the Plans & Benefits template is mapped to the *Tier 1 OOP Maximum* in the AVC, depending on the logic above.
- If the plan has multiple in network tiers, The *Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)–In Network (Tier 2)–Individual* or *Maximum Out of Pocket*

for *Medical and Drug EHB Benefits (Total)–Combined In/Out Network–Individual* value in the Plans & Benefits template is mapped to the *Tier 2 OOP Maximum* in the AVC.

Figure 11-11 shows the integrated medical and drug OOPM fields in the Plans & Benefits template, and Figure 11-12 shows a corresponding example in the AVC.

**Figure 11-11. Maximum Out of Pocket for Medical and Drug and EHB Benefits (Total) Fields in Plans & Benefits Template**

AJ	AK	AL	AM	AN	AO	AP	AQ
<b>Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)</b>							
<b>In Network</b>		<b>In Network (Tier 2)</b>		<b>Out of Network</b>		<b>Combined In/Out Network</b>	
<i>Individual</i>	<i>Family</i>	<i>Individual</i>	<i>Family</i>	<i>Individual</i>	<i>Family</i>	<i>Individual</i>	<i>Family</i>
\$4,000	\$8,000			\$10,000	\$20,000	Not Applicable	Not Applicable

**Figure 11-12. Integrated Deductible and OOP Maximum in AVC**

<b>Tier 1 Plan Benefit Design</b>			
	<b>Medical</b>	<b>Drug</b>	<b>Combined</b>
Deductible (\$)			\$1,500.00
Coinsurance (% , Insurer's Cost Share)			70.00%
OOP Maximum (\$)			\$4,000.00
OOP Maximum if Separate (\$)			

If *Medical & Drug Maximum Out of Pocket Integrated?* is equal to **No** in the Cost Sharing Variances worksheet of the Plans & Benefits template, the *Use Separate OOP Maximum for Medical and Drug Spending?* checkbox in the AVC is checked. In the case of separate OOPMs:

- The *Maximum Out of Pocket for Medical EHB Benefits–In Network–Individual* or *Maximum Out of Pocket for Medical EHB Benefits–Combined In/Out Network–Individual* value in the Plans & Benefits template is mapped to the *Tier 1 Medical OOP Maximum* in the AVC.
- The *Maximum Out of Pocket for Drug EHB Benefits–In Network–Individual* or *Maximum Out of Pocket for Drug EHB Benefits–Combined In/Out Network–Individual* value in the Plans & Benefits template is mapped to the *Tier 1 Drug OOP Maximum* in the AVC.
- If the plan has multiple in network tiers:
  - The *Maximum Out of Pocket for Medical EHB Benefits–In Network (Tier 2)–Individual* or *Maximum Out of Pocket for Medical EHB Benefits–Combined In/Out Network–Individual* value in the Plans & Benefits template is mapped to the *Tier 2 Medical OOP Maximum* in the AVC.
  - The *Maximum Out of Pocket for Drug EHB Benefits–In Network (Tier 2)–Individual* or *Maximum Out of Pocket for Drug EHB Benefits–Combined In/Out Network–*

*Individual* value in the Plans & Benefits template is mapped to the *Tier 2 Drug OOP Maximum* in the AVC.

Figure 11-13 shows the separate medical and drug OOPM fields in the Plans & Benefits template, and Figure 11-14 shows a corresponding example in the AVC.

**Figure 11-13. Maximum Out Of Pocket for Medical EHB Benefits and Maximum Out Of Pocket for Drug EHB Benefits Fields in Plans & Benefits Template**

T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
Maximum Out of Pocket for Medical EHB Benefits								Maximum Out of Pocket for Drug EHB Benefits							
In Network		In Network (Tier 2)		Out of Network		Combined In/Out Network		In Network		In Network (Tier 2)		Out of Network		Combined In/Out Network	
Individual	Family	Individual	Family	Individual	Family	Individual	Family	Individual	Family	Individual	Family	Individual	Family	Individual	Family
\$3,000	\$6,000			\$8,000	\$16,000	Not Applicab	Not Applicab	\$1,000	\$2,000			\$5,000	\$10,000	Not Applicab	Not Applicab

**Figure 11-14. Separate Deductible and OOP Maximum in AVC**

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible (\$)	\$1,500.00	\$500.00	
Coinsurance (% , Insurer's Cost Share)	80.00%	80.00%	
OOP Maximum (\$)			
OOP Maximum if Separate (\$)	\$3,000.00	\$1,000.00	

The AVC will return an error to the Plans & Benefits template when the sum of the medical and drug OOPMs exceeds \$6,500. Small group plans with multiple benefit administrators may, under certain circumstances, have combined medical and drug OOPMs that exceed \$6,500. These small group plans should select **Yes** in the *Unique Plan Design?* field on the Benefits Package worksheet, and fill in the *Issuer Actuarial Value* field on the Cost Share Variances worksheet. These plans designs are incompatible with the AVC and the issuer must submit an actuarial certification among other requirements in accordance with the final rule. (For more details see the discussion on the annual limitation on cost sharing in the “2014 Letter to Issuers on Federally-facilitated and State Partnership Exchanges” at: [http://cciio.cms.gov/resources/regulations/Files/2014\\_letter\\_to\\_issuers\\_04052013.pdf](http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf))

The AVC does not allow a plan to have separate OOPMs if it has an integrated medical and drug deductible. If *Medical & Drug Maximum Out of Pocket Integrated?* is equal to **No** and *Medical & Drug Deductibles Integrated?* is equal to **Yes** in the Plans & Benefits template, the Plans & Benefits template will return an error when attempting to calculate the AV.

### Deductibles

If *Medical & Drug Deductibles Integrated?* is equal to **Yes** in the Cost Sharing Variances worksheet of the Plans & Benefits template, the *Use Integrated Medical and Drug Deductible?* checkbox in the AVC is checked. In the case of integrated deductibles:

- The *Combined Medical & Drug EHB Deductible–In Network–Individual* or *Combined Medical & Drug EHB Deductible–Combined In/Out Network–Individual* value in the Plans & Benefits template is mapped to the *Tier 1 Combined Deductible* in the AVC.

- If the plan has multiple in network tiers, the *Combined Medical & Drug EHB Deductible–In Network (Tier 2)–Individual* or *Combined Medical & Drug EHB Deductible–Combined In/Out Network–Individual* value in the Plans & Benefits template is mapped to the *Tier 2 Combined Deductible* in the AVC.

Figure 11-15 shows the integrated deductible fields in the Plans & Benefits template, and Figure 11-12 shows a corresponding example in the AVC.

**Figure 11-15. Combined Medical and Drug EHB Deductible Fields in Plans & Benefits Template**

BL	BM	BN	BO	BP	BQ	BR	BS	BT	BU
<b>Combined Medical &amp; Drug EHB Deductible</b>									
<b>In Network</b>			<b>In Network (Tier 2)</b>			<b>Out of Network</b>		<b>Combined In/Out Network</b>	
<i>Individual</i>	<i>Family</i>	<i>Default Coinsurance</i>	<i>Individual</i>	<i>Family</i>	<i>Default Coinsurance</i>	<i>Individual</i>	<i>Family</i>	<i>Individual</i>	<i>Family</i>
\$1,500	\$3,000	30%	\$2,000	\$4,000	40%	\$5,000	\$10,000	Not Applicable	Not Applicable
\$0	\$0	0%	\$0	\$0	0%	\$0	\$0	\$0	\$0
\$1,500	\$3,000	30%	\$2,000	\$4,000	40%	\$5,000	\$10,000	Not Applicable	Not Applicable

If *Medical & Drug Deductibles Integrated?* is equal to **No** in the Cost Sharing Variances worksheet of the Plans & Benefits template, the *Use Integrated Medical and Drug Deductible?* checkbox in the AVC is unchecked. In the case of separate medical and drug deductibles:

- The *Medical EHB Deductible–In Network–Individual* or *Medical EHB Deductible–Combined In/Out Network–Individual* value in the Plans & Benefits template is mapped to the *Tier 1 Medical Deductible* in the AVC.
- The *Drug EHB Deductible–In Network–Individual* or *Drug EHB Deductible–Combined In/Out Network–Individual* value in the Plans & Benefits template is mapped to the *Tier 1 Drug Deductible* in the AVC.
- If the plan has multiple in network tiers:
  - The *Medical EHB Deductible–In Network (Tier 2)–Individual* or *Medical EHB Deductible–Combined In/Out Network–Individual* value in the Plans & Benefits template is mapped to the *Tier 2 Medical Deductible* in the AVC.
  - The *Drug EHB Deductible–In Network (Tier 2)–Individual* or *Drug EHB Deductible–Combined In/Out Network–Individual* value in the Plans & Benefits template is mapped to the *Tier 2 Drug Deductible* in the AVC.

Figure 11-16 and Figure 11-17 show the separate medical and drug deductible fields, respectively, in the Plans & Benefits template, and Figure 11-18 shows a corresponding example of separate medical and drug deductibles in the AVC.

**Figure 11-16. Medical EHB Deductible fields in Plans & Benefits Template**

AR	AS	AT	AU	AV	AW	AX	AY	AZ	BA
<b>Medical EHB Deductible</b>									
<b>In Network</b>			<b>In Network (Tier 2)</b>			<b>Out of Network</b>		<b>Combined In/Out Network</b>	
<i>Individual</i>	<i>Family</i>	<i>Default Coinsurance</i>	<i>Individual</i>	<i>Family</i>	<i>Default Coinsurance</i>	<i>Individual</i>	<i>Family</i>	<i>Individual</i>	<i>Family</i>
\$1,500	\$3,000	20%	\$2,000	\$4,000	30%	\$3,000	\$6,000	Not Applicable	Not Applicable
\$0	\$0	0%	\$0	\$0	0%	\$0	\$0	\$0	\$0
\$1,500	\$3,000	20%	\$2,000	\$4,000	30%	\$3,000	\$6,000	Not Applicable	Not Applicable

**Figure 11-17. Drug EHB Deductible Fields in Plans & Benefits Template**

BB	BC	BD	BE	BF	BG	BH	BI	BJ	BK
<b>Drug EHB Deductible</b>									
<b>In Network</b>			<b>In Network (Tier 2)</b>			<b>Out of Network</b>		<b>Combined In/Out Network</b>	
<i>Individual</i>	<i>Family</i>	<i>Default Coinsurance</i>	<i>Individual</i>	<i>Family</i>	<i>Default Coinsurance</i>	<i>Individual</i>	<i>Family</i>	<i>Individual</i>	<i>Family</i>
\$500	\$1,000	20%	\$800	\$1,600	30%	\$2,000	\$4,000	Not Applicable	Not Applicable
\$0	\$0	0%	\$0	\$0	0%	\$0	\$0	\$0	\$0
\$500	\$1,000	20%	\$800	\$1,600	30%	\$2,000	\$4,000	Not Applicable	Not Applicable

**Figure 11-18. Separate Medical and Drug Deductibles and Integrated OOP Maximum in AVC**

<b>Tier 1 Plan Benefit Design</b>			
	<b>Medical</b>	<b>Drug</b>	<b>Combined</b>
Deductible (\$)	\$1,500.00	\$500.00	
Coinsurance (% , Insurer's Cost Share)	80.00%	80.00%	
OOP Maximum (\$)	\$4,000.00		
OOP Maximum if Separate (\$)			

**Default Coinsurance**

While the coinsurance values in the Plans & Benefits template represent the percentage of costs that the enrollee pays for a given service, the coinsurance values in the AVC represent the percentage of costs the issuer pays. Thus, the coinsurance values entered into the AVC must be set equal to 1–X%, where X% is the coinsurance value entered in the Plans & Benefits template. For example, if enrollees pay 10 percent of Specialist Visit costs, the coinsurance in the Plans & Benefits template would be equal to 10 percent. The coinsurance in the AVC would be equal to 90 percent to represent the 90 percent of costs incurred by the issuer.

If the plan has an integrated medical and drug deductible, it also must have an integrated default coinsurance in the AVC. If *Medical & Drug Deductibles Integrated?* is equal to **Yes** in the Cost Sharing Variances worksheet of the Plans & Benefits template:

- One minus the *Combined Medical & Drug EHB Deductible–In Network–Default Coinsurance* value in the Plans & Benefits template is mapped to the default *Tier 1 Combined Coinsurance* in the AVC (found in the Tier 1 Plan Benefit Design table).

- If the plan has multiple in network tiers, one minus the *Combined Medical & Drug EHB Deductible–In Network (Tier 2)–Default Coinsurance* value in the Plans & Benefits template is mapped to the default *Tier 2 Combined Coinsurance* in the AVC (found in the Tier 2 Plan Benefit Design table).

Figure 11-15 shows the integrated medical and drug default coinsurance fields in the Plans & Benefits template, and Figure 11-12 shows a corresponding example in the AVC.

If the plan has separate medical and drug deductibles, it also must have separate default coinsurance values in the AVC. If *Medical & Drug Deductibles Integrated?* is equal to **No** in the Cost Sharing Variances worksheet of the Plans & Benefits template:

- One minus the *Medical EHB Deductible–In Network–Default Coinsurance* value in the Plans & Benefits template is mapped to the default *Tier 1 Medical Coinsurance* in the AVC (found in the Tier 1 Plan Benefit Design table).
- One minus the *Drug EHB Deductible–In Network–Default Coinsurance* value in the Plans & Benefits template is mapped to the default *Tier 1 Drug Coinsurance* in the AVC.
- If the plan has multiple in network tiers:
  - One minus the *Medical EHB Deductible–In Network (Tier 2)–Default Coinsurance* value in the Plans & Benefits template is mapped to the default *Tier 2 Medical Coinsurance* in the AVC (found in the Tier 2 Plan Benefit Design table).
  - One minus the *Drug EHB Deductible–In Network (Tier 2)–Default Coinsurance* value in the Plans & Benefits template is mapped to the default *Tier 2 Drug Coinsurance* in the AVC.

Figure 11-16 and Figure 11-17 show the separate medical and drug default coinsurance fields, respectively, in the Plans & Benefits template, and Figure 11-18 shows a corresponding example in the AVC.

### Subject to Coinsurance?

For each benefit, if *Coinsurance–In Network (Tier 1)* is equal to **X% Coinsurance after deductible** or **X%** in the Plans and Benefits template, then the *Tier 1 Subject to Coinsurance?* checkbox for the corresponding benefit in the AVC is checked. For a plan with multiple in network tiers, if *Coinsurance–In Network (Tier 2)* is equal to **X% Coinsurance after deductible** or **X%** in the Plans and Benefits template, the *Tier 2 Subject to Coinsurance?* checkbox for the corresponding benefit in the AVC is checked.

### Copay Values

For each benefit, if *Copay–In Network (Tier 1)* in the Plans & Benefits template is equal to **\$X Copay before deductible**, **\$X per day**, **\$X per stay**, or **\$X**, the *Tier 1 Copay, if separate* field in the AVC is set equal to X. If *Copay–In Network (Tier 1)* is equal to **\$X Copay after deductible** and the corresponding *Coinsurance–In Network (Tier 1)* field is equal to **No Charge** or **No Charge after deductible**, the *Tier 1 Copay, if separate* field in the AVC is set equal to X. If

*Copay–In Network (Tier 1)* is equal to **No Charge** or **No Charge after deductible**, the *Tier 1 Copay, if separate* field in the AVC is left blank.

When both a coinsurance and copay value are present for a given benefit, the AVC considers only the coinsurance value when calculating costs after the deductible and before the OOPM. Therefore, we would not expect an issuer to enter a copay value into the stand-alone AVC if the given benefit has a copay that enrollees pay only after the deductible as well as a coinsurance. Following this rationale, if *Copay–In Network (Tier 1)* is equal to **\$X Copay after deductible** and *Coinsurance–In Network (Tier 1)* is equal to **X% Coinsurance after deductible** or **X%** in the Plans & Benefits template, the *Tier 1 Copay, if separate* field in the AVC is left blank.

For a plan with multiple in network tiers, the logic described above for Tier 1 also applies to Tier 2.

### Different Coinsurance Values

For each benefit, if the *Tier 1 Subject to Coinsurance?* checkbox in the AVC is checked as described above, to one minus X%, where X% is the coinsurance value from the *Coinsurance–In Network (Tier 1)* field in the Plans & Benefits template, is mapped to the *Tier 1 Coinsurance, if different* field for the corresponding benefit in the AVC. For a plan with multiple in network tiers, if the *Tier 2 Subject to Coinsurance?* checkbox in the AVC is checked, one minus X%, where X% is the coinsurance value from the *Coinsurance–In Network (Tier 2)* field, is mapped to the *Tier 2 Coinsurance, if different* field for the corresponding benefit in the AVC.

The AVC treats **No Charge** and 0% coinsurance differently when a benefit's copay is greater than \$0. If the benefit has coinsurance equal to **No Charge** and a copay greater than \$0, the relevant *Subject to Coinsurance?* checkbox in the AVC is unchecked, and the AVC assumes that the enrollee pays a copay until reaching the OOPM. If the benefit has a coinsurance equal to 0% and a copay greater than \$0, the relevant *Subject to Coinsurance?* checkbox in the AVC is checked and one minus X% is entered into the relevant *Coinsurance, if different* field in the AVC. In the latter case, the AVC assumes that the enrollee pays a copay until meeting the deductible, and then pays nothing after the deductible.

### Benefit Categories

Table 11-1 shows the alignment of benefit categories in the Plans & Benefits template and the AVC, and Figure 11-10 shows the benefit categories, along with their cost-sharing fields, in the AVC. If a plan does not cover a given benefit, the *Coinsurance, if different* field for the benefit in the AVC is set to 0%, and the *Subject to Coinsurance?* and *Subject to Deductible?* checkboxes are checked. For purposes of the AVC, substituted benefits are considered not covered. Benefits with special considerations are detailed below.

**Table 11-1. Benefit Category Alignment between Plans & Benefits Template and AVC**

Plans & Benefits Template Category Name	AVC Category Name
Emergency Room Services	Emergency Room Services
Inpatient Hospital Services (e.g., Hospital Stay)	All Inpatient Hospital Services (inc. MHSA)
Primary Care Visit to Treat an Injury or Illness	Primary Care Visit to Treat an Injury or Illness (exc. Preventive and X-rays)
Specialist Visit	Specialist Visit
Mental/Behavioral Health Outpatient Services	Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services
Substance Abuse Disorder Outpatient Services	
Imaging (CT/PET Scans, MRIs)	Imaging (CT/PET Scans, MRIs)
Rehabilitative Speech Therapy	Rehabilitative Speech Therapy
Rehabilitative Occupational and Rehabilitative Physical Therapy	Rehabilitative Occupational and Rehabilitative Physical Therapy
Preventive Care/Screening/Immunization	Preventive Care/Screening/Immunization
Laboratory Outpatient and Professional Services	Laboratory Outpatient and Professional Services
X-rays and Diagnostic Imaging	X-rays and Diagnostic Imaging
Skilled Nursing Facility	Skilled Nursing Facility
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
Outpatient Surgery Physician/Surgical Services	Outpatient Surgery Physician/Surgical Services
Generic Drugs	Generics
Preferred Brand Drugs	Preferred Brand Drugs
Non-Preferred Brand Drugs	Non-Preferred Brand Drugs
Specialty Drugs	Specialty Drugs (i.e., high-cost)

***Inpatient Hospital Services***

If the Inpatient Hospital Services *Copay–In Network (Tier 1)* in the Plans & Benefits template is equal to **\$X Copay per Day**, the *Apply Inpatient Copay per Day?* checkbox in the AVC is checked. If the Inpatient Hospital Services copay is charged per day for Tier 1, the AVC automatically assumes that the Inpatient Hospital Services copay is charged per day for Tier 2, if applicable, as well.

If *Maximum Number of Days for Charging an Inpatient Copay?* is equal to a whole number between 1 and 10 in the Benefits Package worksheet of the Plans & Benefits template, then the *Set a Maximum Number of Days for Charging an IP Copay?* checkbox in the AVC is checked, and *Maximum Number of Days for Charging an Inpatient Copay?* field in the Plans & Benefits template is mapped to *# Days (1–10)* in the AVC. If the *Maximum Number of Days for Charging an Inpatient Copay?* field is blank in the Plans & Benefits template, the *Set a Maximum Number of Days for Charging an IP Copay?* checkbox in the AVC is unchecked, and *# Days (1–10)* in the AVC is left blank.

The *Maximum Number of Days for Charging an Inpatient Copay?* field is set only once in the Plans & Benefits template for each plan and cannot differ among silver plan CSR and limited cost sharing plan variations. Furthermore, The *Set a Maximum Number of Days for Charging an*



*IP Copay?* checkbox and *# Days (1–10)* field are input only once in the AVC, and the values cannot vary between Tier 1 and Tier 2. Figure 11-19 shows the *Maximum Number of Days for Charging an Inpatient Copay?* field in the Plans & Benefits template, and Figure 11-20 shows the corresponding checkbox and field in the AVC.

**Figure 11-19. AV Calculator Additional Benefit Design Fields in Plans & Benefits Template**

AA	AB	AC	AD
<b>AV Calculator Additional Benefit Design</b>			
Maximum Coinsurance for Specialty Drugs	Maximum Number of Days for Charging an Inpatient Copay?	Begin Primary Care Cost-Sharing After a Set Number of Visits?	Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?
\$200	5	3	

**Figure 11-20. Maximum Number of Days for IP Copay Checkbox and Field in AVC**

Set a Maximum Number of Days for Charging an IP Copay? <input checked="" type="checkbox"/>
# Days (1-10): 5

### Skilled Nursing Facility

If the Skilled Nursing Facility *Copay–In Network (Tier 1)* in the Plans & Benefits template is equal to \$X Copay per Day, the *Apply Skilled Nursing Facility Copay per Day?* checkbox in the AVC is checked. If the skilled nursing facility copay is charged per day for Tier 1, the AVC automatically assumes that the skilled nursing facility copay is charged per day for Tier 2, if applicable, as well.

### Primary Care

If *Begin Primary Care Cost-Sharing After a Set Number of Visits?* is equal to a whole number between 1 and 10 in the Benefits Package tab of the Plans & Benefits template, the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* checkbox in the AVC is checked, and the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* field in the Plans & Benefits template is mapped to *# Visits (1–10)* in the AVC. If the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* field is blank in the Plans & Benefits template, the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* checkbox in the AVC is unchecked, and *# Visits (1–10)* in the AVC is left blank.

If *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* is equal to a whole number between 1 and 10 in the Benefits Package tab of the Plans & Benefits template, the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* checkbox in the AVC, and the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* field in the Plans & Benefits template is mapped to *# Copays (1–10)* in the AVC. If the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* field is blank in the Plans & Benefits template, the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* checkbox in the AVC is unchecked, and *# Copays (1–10)* in the AVC is left blank.

The *Begin Primary Care Cost-Sharing After a Set Number of Visits?* and *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* fields, shown in Figure 11-19, are set only once in the Plans & Benefits template for each plan and cannot differ among silver plan CSR and limited cost sharing plan variations. Furthermore, these primary care fields and checkboxes, shown in Figure 11-21, are set only once in the AVC, and the values cannot vary between Tier 1 and Tier 2.

**Figure 11-21. Primary Care Options in AVC**

49	Begin Primary Care Cost-Sharing After a Set Number of Visits?	<input checked="" type="checkbox"/>
50	# Visits (1-10):	3
51	Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	<input type="checkbox"/>
52	# Copays (1-10):	

### **Outpatient Facility Fee and Surgery Physician/Surgical Services**

The AVC does not support copay values for the Outpatient Facility Fee or Outpatient Surgery Physician/Surgical Services benefit categories. If either of these benefit categories has a copay in the Plans & Benefits template, the AVC will return an error. For purposes of the AVC, issuers may convert a plan’s Outpatient Facility Fee or Outpatient Surgery Physician/Surgical Services copay into an estimated coinsurance and enter this coinsurance into the Plans & Benefits template.

### **Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services**

The AVC Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services cost-sharing fields are weighted averages of the Mental/Behavioral Health Outpatient Services and the Substance Abuse Disorder Outpatient Services cost-sharing fields in the Plans & Benefits template. If *Coinsurance–In Network (Tier 1)* is equal to **X% Coinsurance after deductible** or **X%** for Mental/Behavioral Health Outpatient Services in the Plans & Benefits template, the *Tier 1 Subject to Coinsurance?* checkbox for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC is checked. Then  $[0.8 \times (\text{Mental/Behavioral Health Outpatient Services–Coinsurance–In Network (Tier 1)})] + [0.2 \times (\text{Substance Abuse Disorder Outpatient Services–Coinsurance–In Network (Tier 1)})]$  is mapped to the *Tier 1 Coinsurance, if different* field for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC.

In the following two scenarios,  $0.8 \times (\text{Mental/Behavioral Health Outpatient Services–Copay–In Network (Tier 1)}) + [0.2 \times (\text{Substance Abuse Disorder Outpatient Services–Copay–In Network (Tier 1)})]$  is mapped to the *Tier 1 Copay, if separate* field for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC:

- When the *Mental/Behavioral Health Outpatient Services–Copay–In Network (Tier 1)* is equal to **\$X** or **\$X before deductible** in the Plans & Benefits template.
- When the *Mental/Behavioral Health Outpatient Services–Copay–In Network (Tier 1)* is equal to **\$X after deductible** and the *Mental/Behavioral Health Outpatient Services–Coinsurance–In Network (Tier 1)* is equal to **No Charge** or **No Charge after deductible** in the Plans & Benefits template.

The logic described in the previous two paragraphs also applies to the Tier 2 coinsurance and copay fields for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services.

The values in the *Subject to Deductible (Tier 1)* and *Subject to Deductible (Tier 2)* fields for Mental/Behavioral Health Outpatient Services in the Plans & Benefits template determine whether to check the Tier 1 and/or Tier 2 Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services *Subject to Deductible?* checkboxes in the AVC.

### Drugs

The Plans & Benefits template and the AVC require cost sharing for four types of drugs: Generic Drugs, Preferred Brand Drugs, Non-Preferred Brand Drugs, and Specialty Drugs. Please see Chapter 10: Instructions for the Plans & Benefits Application Section for recommendations on how to map the cost sharing entered on the Prescription Drug template into the drug benefit categories in the Plans and Benefits template.

The AVC does not allow a drug benefit to have both a copay and a coinsurance not equal to the relevant default coinsurance. If a copay and a coinsurance are entered for a drug benefit in the Plans & Benefits template, the AVC will return an error.

### Specialty Drugs

If the *Maximum Coinsurance for Specialty Drugs* field is not blank in the Benefits Package worksheet of the Plans & Benefits template, then the *Set a Maximum on Specialty Rx Coinsurance Payments?* checkbox in the AVC is checked, and the *Maximum Coinsurance for Specialty Drugs* field in the Plans & Benefits template is mapped to the *Specialty Rx Coinsurance Maximum* field in the AVC. If the *Maximum Coinsurance for Specialty Drugs* field is blank in the Plans & Benefits template, the *Set a Maximum on Specialty Rx Coinsurance Payments?* checkbox in the AVC is unchecked, and the *Specialty Rx Coinsurance Maximum* field in the AVC is left blank.

The *Maximum Coinsurance for Specialty Drugs* field, shown in Figure 11-19, is set only once in the Plans & Benefits template for each plan and cannot differ among the silver plan CSR and limited cost sharing plan variations. Furthermore, the specialty drugs maximum coinsurance checkbox and amount field, shown in Figure 11-22, are set only once in the AVC, and the values do not vary between Tier 1 and Tier 2.

**Figure 11-22. Specialty Drugs Maximum Payment Fields in AVC**

Set a Maximum on Specialty Rx Coinsurance Payments?	<input checked="" type="checkbox"/>
Specialty Rx Coinsurance Maximum:	\$200

### Zero Cost Sharing and Limited Cost Sharing Plan Variations

Zero cost sharing plan variations, which are required to have zero cost sharing for all EHB categories, are automatically assigned an AV of 100 percent because they cover 100 percent of the average enrollee's costs. Limited cost sharing plan variations, which are required to have the same cost sharing and OOPMs as the standard plan for all EHB categories, must have the same AV as the standard plan. Although limited cost sharing plans variations must provide zero cost sharing to certain individuals for EHB items or services that are furnished directly by the Indian

Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services (45 CFR 156.420(b)(2)), these CSRs are not represented in the Plans & Benefits template and are not included in the AV calculation.