1. CIRCUMSTANCES NECESSITATING COLLECTION OF INFORMATION

The Patient Protection and Affordable Care Act, Pub. L. 111-148, was signed into law on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, P. L. 111-152, was signed into law on March 30, 2010 (collectively known as the "Affordable Care Act"). The Affordable Care Act amends the Public Health Service Act (PHS Act) by adding section 2715 "Development and Utilization of Uniform Explanation of Coverage Documents and Standardized Definitions." This section directs the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury (collectively, the Departments), in consultation with the National Association of Insurance Commissioners (NAIC) and a working group comprised of stakeholders, to develop standards for use by a group health plan and a health insurance issuer in compiling and providing to applicants, enrollees, policyholders, and certificate holders a summary of benefits and coverage (SBC) explanation that accurately describes the benefits and coverage under the applicable plan or coverage. Section 2715 also requires 60-days advance notice of any material modification in any of the terms of the plan or coverage that is not reflected in the most recently provided summary and the development of standards for the definitions of terms used in health insurance coverage.

A notice of proposed rulemaking (NPRM) was published on August 22, 2011 (76 FR 52442) with an accompanying document (76 FR 52475) containing the templates, instructions, and related materials for implementing the disclosure provisions under PHS Act 2715. The NPRM proposed 54.9815-2715 to Title 26 of the Code of Federal Regulations. A final rule was published on February 14, 2012. A second notice of proposed rulemaking ("2014 NPRM") was published on December 30, 2014 (79 FR 78577) to propose revisions to the regulation as well as the templates, instructions, and related materials. On March 30, 2015, the Departments released an FAQ stating that the Departments intend to finalize changes to the regulations in the near future but intend to utilize consumer testing and offer an opportunity for the public, including the NAIC, to provide further input before finalizing revisions to the SBC template and associated documents. A final rule, without final revisions to the SBC template and associated documents, was published on June 16, 2015 ("2015 Final Rule").

Section 54.9815-2715(a)(1) requires a group health plan and a health insurance issuer to provide a written summary of benefits and coverage for each benefit package to entities and individuals at specified points in the enrollment process.

As specified in § 54.9815-2715(a)(2), a plan or issuer will populate the SBC with the applicable plan or coverage information, including the following: (1) a description of the coverage, including cost sharing, for each category of benefits identified in guidance by the Secretary; (2) exceptions, reductions, and limitations of the coverage; (3) the cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations; (4) the renewability and continuation of coverage provisions; (5) coverage examples that illustrate common benefits scenarios (including pregnancy and serious or chronic medical conditions) and related cost sharing; (6) contact information for questions; (7) for issuers, an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained; (8) for plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of network providers; (9) for plans and issuers that provide prescription drug coverage through a formulary, an Internet address (or similar contact information) for obtaining information on prescription drug coverage; and (10) an Internet address (or similar contact information) where a consumer may review and obtain the uniform glossary; and (11) a statement about whether the plan or coverage provides minimum essential coverage as defined under section 5000A(f) of the Internal Revenue Code and whether the plan's or coverage's share of the total allowed costs of coverage meets applicable requirements.

In order to produce coverage examples, a plan or issuer will simulate claims processing for clinical care provided under each scenario using the services, dates of service, billing codes, and allowed amounts provided by HHS. Benefits scenarios will be based on recognized treatment guidelines as defined by the National Guideline Clearinghouse. Allowed amounts for each service will be based on national averages. Plans and issuers will follow instructions for estimating and displaying costs in a standardized format authorized by HHS. The purpose of the coverage examples tool is to help consumers synthesize the impact of multiple coverage provisions in order to compare the level of protection offered by a plan or coverage for common benefit scenarios. In the first year of implementation, two coverage examples (having a baby and managing type 2 diabetes) were required in the SBC. In the 2014 proposed rule, the Departments proposed to add a third coverage example, simple foot fracture.

Because the statute additionally requires the Secretary to "provide for the development of standards for the definitions of terms used in health insurance coverage," including specified insurance-related and medical terms, the Departments have interpreted this provision as requiring plans and issuers to make available a uniform glossary of health coverage and medical terms that is three (3) double-sided pages in length. Plans and issuers must include an Internet address in the SBC for consumers to access the glossary and provide a paper copy of the glossary within 7 days upon request. Plans and issuers may not modify the glossary provided in guidance by the Departments.

Finally, "if a group health plan or health insurance issuer makes any material modification in

any of the terms of the plan or coverage involved (as defined for purposes of section 102 of the Employee Retirement Income Security Act (ERISA)) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer must provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective." Thus, the Departments will require plans and issuers to provide 60-days advance notice of any material modification in any of the terms of the plan or coverage that (1) affects the information required to be included the SBC; (2) occurs during the plan or policy year, other than in connection with renewal or reissuance of the coverage; and (3) is not otherwise reflected in the most recently provided SBC.

A plan or issuer may satisfy this requirement by providing either an updated SBC or a separate notice describing the modification.

IRS is requesting three-year approval by the Office of Management and Budget so that plans and issuers may begin using the revised forms for making the disclosures under PHS Act section 2715 and the implementing regulations.

2. USE OF DATA

This information collection will help to ensure that approximately 130.5 million participants and beneficiaries enrolled in ERISA covered group health plans receive the consumer protections of the Affordable Care Act. Employers, employees, and individuals will use this valuable information to compare plan or coverage options prior to selecting coverage and to understand the terms of, and extent of medical benefits offered by, their plan or coverage (or exceptions to such coverage or benefits) once they have coverage.

3. USE OF IMPROVED INFORMATION TECHNOLOGY TO REDUCE BURDEN.

The SBC template will be made available to plans and issuers in MS Word, a widely available word processing application. Plans and issuers may choose to complete the template manually or to develop systems to capture and report the relevant data in the required standardized format.

With respect to the coverage examples, HHS will make available in an Excel worksheet the clinical benefits scenario(s), including specific services, dates of service, billing codes, and allowed charges associated with each scenario. Plans and issuers will simulate processing of claims under each benefits scenario(s) to illustrate how a consumer could expect to share costs with the plan or coverage. Plans and issues may either generate these outputs using automated systems or perform calculations manually, such as using Excel.

An issuer is permitted to provide the SBC may be provided either in paper form or, if certain safeguards are met, in electronic form. Electronic disclosure in the group markets, where

appropriate, will help reduce the cost and burden of distributing this information. The Departments anticipate approximately 70 percent electronic distribution in the individual market and approximately 38 percent electronic distribution in the group market.[1]

4. EFFORTS TO IDENTIFY DUPLICATION

Under the federal health care reform insurance Web portal requirements, 45 CFR 159.200, HHS collects summary information about health insurance products that are available in the individual market. To reduce duplication for purposes of the SBC collection, we will permit individual market issuers compliant with the Web portal collection to voluntarily report to the Web portal for display the five additional data elements (not currently collected through the Web portal collection) for each coverage example. Issuers providing the additional data elements to Web portal collection will be deemed to satisfy the requirement to provide an SBC to individuals in the individual market requesting summary information, prior to submitting an application for coverage.

In addition, under the disclosure requirements at 29 CFR 2520, ERISA-covered group health plans are already required to disclose to participants and beneficiaries similar plan information in a summary plan description (SPD). This collection will require plans to summarize such SPD information so consumers may better understand the terms of the plan and meaningfully compare plan options. While this collection will thus duplicate some information collected under ERISA, the burden of compiling and providing it in the required standardized format is reduced, because it is readily available to plan sponsors and administrators and disclosed as part of their current operations.

5. METHODS TO MINIMIZE BURDEN ON SMALL BUSINESSES OR OTHER SMALL ENTITIES

The regulation applies to all employee benefit plans and therefore is likely to affect small entities (small business, small plans) that provide benefits. A large majority of small plans purchase administration services from insurers, HMOs, and other service providers, and the DOL has taken this fact into account in deriving its burden estimates. These service providers typically develop a single processing system to service a large number of customers, including small

entities. Thus, the cost of preparing and distributing the disclosures is spread thinly over a large number of small plans. Moreover, small plans and their respective enrollees benefit equally

1 The Departments' estimate is based on statistics published by the National Telecommunications and Information Administration, which indicate 30 percent of Americans do not use the Internet. U.S. Department of Commerce, National Telecommunications and Information Administration, *Digital Nation* (February 2010), available at http://www.ntia.doc.gov/reports/2010/NTIA_internet_use_report_Feb2010.pdf.

from the service provider's expertise and ability to provide the disclosures. Finally, the vast majority of health insurance issuers are not small businesses.[2]

6. CONSEQUENCES OF LESS FREQUENT COLLECTION ON FEDERAL PROGRAMS OR POLICY ACTIVITIES

This collection is required to fulfill the statutory requirements under PHS Act section 2715. This collection will ensure that at multiple points in the enrollment process consumers have accurate information with which to understand and compare plan and coverage options. If this collection is not conducted, or is conducted less frequently, consumers will not receive the protections to which they are entitled under the Affordable Care Act. If, however, information collected in the first instance does not change in subsequent collections, duplicate collections are typically not required during the plan or policy year. Furthermore, multiple collections are not required in the case of family coverage, if covered family members reside at the same address. These provisions will limit the collection burden on the industry while providing meaningful and consistent information to consumers.

7. SPECIAL CIRCUMSTANCES REQUIRING DATA COLLECTION TO BE INCONSISTENT WITH GUIDELINES IN 5 CFR 1320.5(d)(2)

- *requiring respondents to report information to the agency more often than quarterly;*
- *requiring respondents to prepare a written response to a collection of information in fewer than 30 days after receipt of it;*
- *requiring respondents to submit more than an original and two copies of any document;*
- *requiring respondents to retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;*
- *in connection with a statistical survey, that is not designed to produce valid and reliable results that can be generalized to the universe of study;*
- *requiring the use of a statistical data classification that has not been reviewed and approved by OMB;*
- *that includes a pledge of confidentiality that is not supported by authority established in statute or regulation, that is not supported by disclosure and data security policies that are consistent*

2 The Small Business Administration threshold for a small business is $7 million in annual receipts for both health insurers (North American Industry Classification System, or NAICS, Code 524114). Using total Accident and Health (A&H) earned premiums from the 2009 National Association of Insurance Commissioners (NAIC) Health and Life Blank as a proxy for annual receipts, we estimate 28 small entities with less than $7 million in A&H earned premiums offering individual or group comprehensive major medical coverage; however, this estimate may overstate the actual number of small health insurance issuers offering such coverage, since it does not include receipts from these companies' other lines of business.

with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or

- *requiring respondents to submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.*

Plans and issuers are required to provide the SBC to an applicant upon request of an application for, or health coverage information about, a policy, certificate, or contract of insurance and upon request for enrollment pursuant to a special enrollment right. In such instances, disclosure must occur as soon as practicable, but not later than 7 days after receipt of the request. Similarly, upon general request, plans and issuers are required to provide the SBC as soon as practicable, but not later than 7 days after the receipt of the request. Depending on the number of such requests, plans and issuers may have to provide several copies of the SBC.

8. CONSULTATION WITH INDIVIDUALS OUTSIDE OF THE AGENCY ON AVAILABILITY OF DATA, FREQUENCY OF COLLECTION, CLARITY OF INSTRUCTIONS AND FORMS, AND DATA ELEMENTS

The 2014 NPRM was published in the *Federal Register* on December 30, 2014 (79 FR 78577) providing the public with a 60-day period to submit written comments on the rule and the ICR. The Departments received two comments in response to this ICR. These comments have been addressed in below.

Comment 1: Requiring issuers to provide sample certificates of coverage to those shopping for coverage is an unduly burdensome and costly requirement, given the sheer number of certificates an issuer would have to make available. Moreover, any "sample" certificate is bound not to track precisely with the specific coverage the individual is seeking, and will hence mislead consumers. Finally, in issuers' experience, shoppers do not request the actual certificates of coverage and policies before enrolling in coverage. So this requirement adds a great deal of cost, and consumes a great deal of resources, for little to no consumer benefit. There currently is also no standard for the term "sample" as it related to certificates.

Comment 2: We urge the proposed requirement to provide contracts before plan election be dropped. It goes beyond the development and use of SBCs and Uniform Glossaries to a new and costly administrative requirement on employers / plan sponsors and issuers to provide actual or

sample plan forms, insurance policies or contracts to shoppers in the individual and group markets, when SBCs are provided already to assist those shoppers.

Response to 1 & 2: The December 2014 proposed regulations estimated the burden for this requirement to be de minimis because the documents already exist and issuers already have web addresses where the materials can be made available. Additionally, the Departments understand that issuers already frequently make these materials available online to individuals, plan sponsors, and participants and beneficiaries after enrollment in coverage. These final regulations clarify that these documents must be made available online to those shopping for coverage prior to enrollment as well. It is not expected that group health insurance issuers will be providing access to group certificates of coverage prior to execution of the final group certificate of coverage. Instead, the Departments anticipate and expect that the sample group certificate of coverage that underlies the product being marketed and sold, and that have been filed with and approved by a state Department of Insurance, are what will be provided prior to the execution of the actual group certificate of coverage. Therefore, the Departments still believe that the requirement to make these documents available via an Internet web address will result in only a de minimis burden on issuers. Additionally, Departments note that this requirement is not new. It comes from the statutory content requirements found in PHS Act section 2715(b)(3)(I). However, the final rule issued in February 2012 did not make clear whether accessibility via web address was required and whether access was required for individuals and group health plan sponsors shopping for coverage. This final regulations clarifies that accessibility via a web address, and for those shopping for coverage, is required.

The Departments have continued to consult with industry experts, including health insurance issuers and groups representing employers with self-funded health plans, to gain insight into the hour and burden associated with this collection, the tasks and level of effort required, and the availability of data. Furthermore, as required by Section 2715, the Departments consulted the

NAIC to provide further input before finalizing revisions to the SBC template and associated documents. The NAIC convened the Consumer Information (B) Subgroup (Subgroup) comprised of regulators and an advisory working group of consumer representatives, industry representatives and provider groups. The Subgroup held conference calls open to the public. Additionally, the work product underwent consumer testing. On October 14, 2015 the NAIC formally submitted their recommendations to the Departments regarding the revised SBC template and instructions. On December 9, 2015, the NAIC formally submitted their recommendations to the Departments on the SBC uniform glossary.

9. EXPLANATION OF DECISION TO PROVIDE ANY PAYMENT OR GIFT TO RESPONDENTS

.

No payment or gift has been provided to any respondents.

10. ASSURANCE OF CONFIDENTIALITY OF RESPONSES

This information collection request (ICR) requires the disclosure of information regarding, among other things cost-sharing, covered benefits, and exceptions, reductions and limitations on coverage by plans and issuers directly to consumers. The purpose of this collection is to summarize information about the terms of the applicable plan or coverage that is described in fuller detail in the policy, certificate, or contract of insurance or other plan document. Therefore, the Departments believe this collection does not require the disclosure of trade secrets or other confidential information.

11. JUSTIFICATION OF SENSITIVE QUESTIONS

No personally identifiable information (PII) is collected.

12. ESTIMATED BURDEN OF INFORMATION COLLECTION

Each group health plan (2,299,198) and health insurance issuer (544) offering group insurance coverage must provide a summary of benefits and coverage (SBC) to plans and participants at specified points in the enrollment process. This leads to 2,299,742 respondents for this information collection. This disclosure must include, among other things, coverage examples that illustrate common benefits scenarios and related cost sharing. Additionally, plans and issuers must make the uniform glossary available in electronic form, with paper upon request, and provide 60-days advance notice of any material modifications in the plan or coverage.

This analysis includes the coverage examples as part of the SBC disclosure and therefore, the Department calculates a single burden estimate for purposes of this section, assuming the information collection request for the SBC (not including coverage examples) totals six (6) sides of a page in length and assuming the information collection request for coverage examples totals two (2) sides of a page in length.

The Department assumes fully-insured ERISA plans will rely on health insurance issuers and self-insured plans will rely on TPAs to perform these functions. While self-insured plans may prepare SBCs internally, the Department makes this simplifying assumption because most plans appear to rely on issuers and TPAs for the purpose of administrative duties, such as enrollment and claims processing. Thus, the Department uses health insurance issuers and TPAs as the unit of analysis for the purposes of estimating administrative costs.

The Departments estimate there are a total of 544 issuers and 1,050 TPAs affected by this information collection.[3] Because the Department of Health and Human Services shares the hour and cost burden for fully-insured plans with the Departments of Labor and the Treasury, HHS assumes 50 percent of the hour and cost burden estimates for individual issuers and 15 percent of the burden for TPAs to account for those TPAs serving self-insured non-Federal governmental plans. The Departments of Labor and Treasury assume the other 50 percent of the burden related to insurers to account for burden servicing fully insured ERISA plans, and 85 percent of the burden related to TPAs to account for the burden related to ERISA self-insured plans.

To account for variation in costs due to firm size and the number of plans and individuals they service, the Department divides issuer in to small, medium, and large.[4] Accordingly, the Department estimates approximately 175 small, 250 medium, and 75 large issuers. The Department lacks information to create a similar split for TPAs, so assumes a similar distribution there for the Department estimates approximately 368 small, 526 medium, and 158 large TPAs.

3 The estimate for the number of issuers is based on the number of issuers for the group and individual market filing with the Department for the Medical Loss Ratio regulations. The number of TPAs is based on the U.S. Census's 2011 Statistics of U.S. Businesses that reports there are 3,157 TPA's. Previous discussions with industry experts led to assuming about one-third of the TPA's (1,052) could be providing services to self-insured plans.

4 The premium revenue data come from the 2009 NAIC financial statements, also known as "Blanks," where insurers report information about their various lines of business. The Department defines small issuers as those with total earned premiums less than $50 million; medium issuers as those with total earned premiums between $50 million and $999 million; and large issuers as those with total earned premiums of $1 billion or more.

The estimated hour burden and equivalent cost for the collections of information are as follows:

The Department estimates an administrative burden on Issuers and TPAs to make appropriate changes to IT systems and processes and make updates to the SBCs and Coverage examples. It is estimated that large firms will incur 150 hours, medium firms 115 hours and small firms 75 hours to perform these tasks. The burden will be split between IT professionals (55 percent), benefits professionals (40 percent), and legal professions (5 percent) with hourly labor rates of $84.50, $61.90, and $128.34 respectively.[5] Clerical labor

rates are $33.90 per hour.

Table 1 shows the calculations used to obtain the hour burden (123,900 hours) and its equivalent cost burden ($9.6 million) for issuers and TPAs to prepare the SBCs and coverage examples.

In addition clerical hours used to prepare and distribute the disclosures (see question 13 below for more details) would have an hour burden of 739,200 hours with an equivalent cost of $25.1 million.

The total hour burden for this information collection would be 863,100 hours (123,900 from Table 1 + 739,200 from Table 3) with an equivalent cost of $34.7 million.

This burden is split evenly between the Department of Labor and the Treasury.

TABLE 1.-- *Update SBC including Coverage Examples*

	Type of Labor	Number of Firms	Hours Per Firm	Cost per Hour	Total Hour Burden	Total Cost Burden
Issuers						
Large	IT	82	41.3	$85	3,383	$285,821
	Benefits	82	30.0	$62	2,460	$152,274
	Legal	82	3.8	$128		$39,465

5 The Department's estimated 2015 hourly labor rates obtained from mean wage from the 2045 National Occupational Employment Survey (March 2015, Bureau of Labor Statistics http://www.bls.gov/news.release/pdf/ocwage.pdf). Wages are then doubled to provide an estimate of other benefits, and overhead.

					308	
	Sub-Total				6,150	$477,560
Medium	IT	272	31.6	$85	8,602	$726,869
	Benefits	272	23.0	$62	6,256	$387,246
	Legal	272	2.9	$128	782	$100,362
	Sub-Total				15,640	$1,214,477
Small	IT	190	20.6	$85	3,919	$331,134
	Benefits	190	15.0	$62	2,850	$176,415
	Legal	190	1.9	$128	356	$45,721
	Sub-Total				7,125	$553,271
TPAs						
Large	IT	158	70.1	$85	11,080	$936,239
	Benefits	158	51.0	$62	8,058	$498,790
	Legal	158	6.4	$128	1,007	$129,270
	Sub-Total				20,145	$1,564,300
Medium	IT	526	53.8	$85	28,279	$2,389,582
	Benefits	526	39.1	$62	20,567	$1,273,073
	Legal	526	4.9	$128	2,571	$329,940
	Sub-Total				51,417	$3,992,594
Small	IT	368	35.1	$85	12,903	$1,090,304
	Benefits	368	25.5	$62	9,384	$580,870
	Legal	368	3.2	$128	1,173	$150,543

Sub-Total	23,460	$1,821,716
Total	123,937	$9,623,917

13. ESTIMATED TOTAL ANNUAL COST BURDEN TO RESPONDENTS

SBC

The Department estimates that there will be about 68.7 million SBCs delivered with 493,000 going to ERISA plans and 68.2 million going to participants annually.[6]

The Department assumes 50 percent of the SBCs going to plans would be sent electronically while 38 percent of SBCs would be sent electronically to plan participants. Accordingly, the Department estimates that about 26.5 million SBCs would be electronically distributed and about 42.2 million SBCs would be distributed in paper form. The Department assumes there are costs only for paper disclosures, with de minimis costs for electronic disclosures. The SBC, with coverage examples, would be eight pages in length. Paper SBCs sent to participants would have no postage costs as they could be included in mails with other plan materials, however all notices sent to beneficiaries living apart would be mailed and have a 49 cent postage costs. Printing costs would be five cents per page. Each document sent by mail would have a one minute preparation burden, with the task performed by a clerical worker. This clerical hour burden is discussed in question 12 above.

The total cost burden to prepare and distribute the SBC would be $17.0 million.

Uniform Glossary – The Department assumes that 2.5 percent of those who receive paper SBCs will request glossaries in paper form (that is, about 1.25 million glossary requests).

The total cost burden to prepare and distribute the Uniform Glossaries would be $863,000.

Notice of Modifications – The Department assumes that issuers and plans will send notices of modifications to covered individuals, and that 2 percent of covered individuals will receive such notice (1.3 million notices). As with the SBC, 50 percent of plans and 38 percent of policy holders will receive electronic notices. Paper notices are assumed to be of the same length as an SBC, eight pages and will incur a postage cost of 49 cents.

6 Based on the 2012 Current Population Survey the Department estimates there are 58.0 million policy holders in ERISA plans http://www.dol.gov/ebsa/pdf/coveragebulletin2013.pdf table 2.

The total cost burden to prepare and distribute the Notice of Modification would be $726,000.

The total annual cost burden is estimated to be $18.5 million. This burden is split evenly between the Department of Labor and the Treasury.

TABLE 2..-- *Preparation and Distribution Costs: Cost Burden*

	Number of Disclosures	Number of Disclosures Sent on Paper	Material and Printing Costs	Postage Costs	Total Cost Burden
SBC with Coverage Examples to Group Health Plan					
Renewal or Application	493,126	246,563	$98,625	$0	$98,625
Upon Request			$0	$0	$0
Sub-Total	493,126	246,563	$98,625	$0	$98,625
SBC with Coverage Examples To Participants and Beneficiaries					
Upon Application or Eligibility	2,303,000	1,151,500	$460,600	$0	$460,600
Upon Renewal	65,800,000	40,796,000	$16,318,400	$0	$16,318,400
Upon Request			$0	$0	$0
Beneficiaries Living Apart	90,000	90,000	$36,000	$44,100	$80,100
Sub-Total	68,193,000	42,037,500	$16,815,000	$44,100	$16,859,100
Uniform Glossary	1,250,200	1,250,200	$250,040	$612,598	$862,638
Notice of Modification	1,316,000	815,920	$326,368	$399,801	$726,169
Total	71,252,326	44,350,183	$17,490,033	$1,056,499	$18,546,532

TABLE 3.-- Preparation and Distribution Costs: Hour Burden

	Number of Disclosures	Number of Disclosures Sent on Paper	Clerical Hours	Clerical Costs	Total Hour Burden	Total Equivalent Cost
SBC with Coverage Examples to Group Health Plan						
Renewal or Application	493,126	246,563	4,109	$139,308	4,109.38	$139,308
Upon Request			-	$0	-	$0
Sub-Total	493,126	246,563	4,109	$139,308	4,109	$139,308
SBC with Coverage Examples To Participants and Beneficiaries						
Upon Application or Eligibility	2,303,000	1,151,500	19,192	$650,598	19,192	$650,598
Upon Renewal	65,800,000	40,796,000	679,933	$23,049,740	679,933	$23,049,740
Upon Request			-	$0	-	$0
Beneficiaries Living Apart	90,000	90,000	1,500	$50,850	1,500	$50,850
Sub-Total	68,193,000	42,037,500	700,625	$23,751,188	700,625	$23,751,188
Uniform Glossary	1,250,200	1,250,200	20,837	$706,363	20,837	$706,363
Notice of Modification	1,316,000	815,920	13,599	$460,995	13,599	$460,995
Total	71,252,326	44,350,183	739,170	$25,057,853	739,170	$25,057,853

14. ESTIMATED ANNUALIZED COST TO THE FEDERAL GOVERNMENT

.These information collection tools were developed by the Federal government for use by the industry. The Departments will periodically update these forms, as necessary. But because there are no program costs associated with this collection, the annualized cost to the Federal government is minimal.

15. REASONS FOR CHANGE IN BURDEN

Estimates have been adjusted to account for new estimates of the number of issuers, plans, participants and beneficiaries affected by the information collection. Also labor rates have been adjusted.

16. PLANS FOR TABULATION, STATISTICAL ANALYSIS AND PUBLICATION

There are no plans for tabulation, statistical analysis and publication.

17. REASONS WHY DISPLAYING THE OMB EXPIRATION DATE IS INAPPROPRIATE

The Departments request an exemption from displaying the expiration date, as these forms will be used on a continuous basis. To include an expiration date would result in having to discard a potentially large number of forms.

18. EXCEPTION TO THE CERTIFICATION STATEMENT

There are no exceptions to the certification statement.

B. Collections of Information Employing Statistical Methods

The use of statistical methods is not relevant to this collection of information.