Summary of Benefits and Coverage and the Uniform Glossary Required Under the Affordable Care Act
OMB Control Number 1210-0147
April 2019

SUPPORTING STATEMENT FOR PAPERWORK REDUCTION ACT OF 1995 SUBMISSIONS

The Department of Labor, Employee Benefits Security Administration requests an extension without change to the information collections currently approved under OMB Control Number 1210-0147.

1. *Explain the circumstances that make the collection of information necessary. Identify any legal or administrative requirements that necessitate the collection. Attach a copy of the appropriate section of each statute and regulation mandating or authorizing the 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, Pub. 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 directed 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 2590.715-2715 to Title 29 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").

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Section 2590.715-2715(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 § 2590.715-2715(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 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.

2. *Indicate how, by whom, and for what purpose the information is to be used. Except for a new collection, indicate the actual use the agency has made of the information received from the current collection.*

This information collection will help to ensure that 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. *Describe whether, and to what extent, the collection of information involves the use of automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses, and the basis for the decision for adopting this means of collection. Also describe any consideration for using 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 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.

4. *Describe efforts to identify duplication. Show specifically why any similar information already available cannot be used or modified for use for the purposes described in Item 2 above.*

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. *If the collection of information impacts small businesses or other small entities describe any methods used to minimize burden.*

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

6. *Describe the consequence to Federal program or policy activities if the collection is not conducted or is conducted less frequently, as well as any technical or legal obstacles to reducing burden.*

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. *Explain any special circumstances that would cause an information collection to be conducted in a manner:*
   - *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 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. *If applicable, provide a copy and identify the date and page number of publication in the Federal Register of the agency's notice, required by 5 CFR 1320.8(d), soliciting comments on the information collection prior to submission to OMB. Summarize public comments received in response to that notice and describe actions taken by the agency in response to these comments. Specifically address comments received on cost and hour burden.*

   Describe efforts to consult with persons outside the agency to obtain their views on the availability of data, frequency of collection, the clarity of instructions and recordkeeping, disclosure, or reporting format (if any), and on the data elements to be recorded, disclosed, or reported.

   Consultation with representatives of those from whom information is to be obtained or those who must compile records should occur at least once every 3 years -- even if the collection of information activity is the same as in prior periods. There may be circumstances that may preclude consultation in a specific situation. These circumstances should be explained.

   The Department's notice soliciting public comment and providing 60 days for that purpose as required by 5 CFR 1320.8 (d) was published in the Federal Register on October 23, 2018 (83 FR 53500). No comments were received.

9. *Explain any decision to provide any payment or gift to respondents, other than remuneration of contractors or grantees.*

   No payments or gifts are provided to respondents.

10. *Describe any assurance of confidentiality provided to respondents and the basis for the assurance in statute, regulation, or agency policy.*

    No assurance of confidentiality is provided. 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 ICR does not require the disclosure of trade secrets or other confidential information.

11. *Provide additional justification for any questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered*

private. This justification should include the reasons why the agency considers the questions necessary, the specific uses to be made of the information, the explanation to be given to persons from whom the information is requested, and any steps to be taken to obtain their consent.

There are no questions of a sensitive nature.

12. *Provide estimates of the hour burden of the collection of information. The statement should:*
    - *Indicate the number of respondents, frequency of response, annual hour burden, and an explanation of how the burden was estimated. Unless directed to do so, agencies should not conduct special surveys to obtain information on which to base hour burden estimates. Consultation with a sample (fewer than 10) of potential respondents is desirable. If the hour burden on respondents is expected to vary widely because of differences in activity, size, or complexity, show the range of estimated hour burden, and explain the reasons for the variance. Generally, estimates should not include burden hours for customary and usual business practices.*
    - *If this request for approval covers more than one form, provide separate hour burden estimates for each form and aggregate the hour burdens in Item 13.*
    - *Provide estimates of annualized cost to respondents for the hour burdens for collections of information, identifying and using appropriate wage rate categories. The cost of contracting out or paying outside parties for information collection activities should not be included here. Instead, this cost should be included in Item 14.*

    Each group health plan (2,327,339) and health insurance issuer (511) 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 2,237,850 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 are part of the SBC disclosure, therefore the Department calculates a single burden estimates 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 511 issuers and 901 TPAs affected by this information collection.[1] 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.[2] Accordingly, the Department estimates approximately 179 small, 256 medium, and 77 large issuers. The Department lacks information to create a similar split for TPAs, so assumes a similar distribution there for the Department estimates approximately 315 small, 450 medium, and 135 large TPAs.

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 $102.74, $85.42, and $133.29 respectively.[3] Clerical labor rates are $52.09 per hour.

Table 1 shows the calculations used to obtain the hour burden (108,489 hours) and its

1 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 2016 Statistics of U.S. Businesses that reports there are 2,702 TPA's. Previous discussions with industry experts led to assuming about one-third of the TPA's (901) could be providing services to self-insured plans.
2 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.
3 For more information on how the Department estimates labor costs see: https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/technical-appendices/labor-cost-inputs-used-in-ebsa-opr-ria-and-pra-burden-calculations-july-2017.pdf

equivalent cost burden ($10.6 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 548,041 hours with an equivalent cost of $28.6 million.

The total hour burden for this information collection would be 656,530 hours (108,489 from Table 1 + 548,041 from Table 3) with an equivalent cost of $39.1 million.

This burden is split evenly between the Departments of Labor and the Treasury, therefore the DOLs share is 328,265 hours.

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	77	41.3	$103	3,176	$326,328
	Benefits	77	30.0	$85	2,310	$197,320
	Legal	77	3.8	$133	289	$38,487
	Sub-Total				5,775	$562,136
Medium	IT	256	31.6	$103	8,096	$831,783
	Benefits	256	23.0	$85	5,888	$502,953
	Legal	256	2.9	$133	736	$98,101
	Sub-Total				14,720	$1,432,837
Small	IT	179	20.6	$103	3,692	$379,303
	Benefits	179	15.0	$85	2,685	$229,353
	Legal	179	1.9	$133	336	$44,735
	Sub-Total					$653,391

					6,713	
TPAs						
Large	IT	135	70.1	$103	9,467	$972,627
	Benefits	135	51.0	$85	6,885	$588,117
	Legal	135	6.4	$133	861	$114,713
	Sub-Total				17,213	$1,675,456
Medium	IT	450	53.8	$103	24,193	$2,485,602
	Benefits	450	39.1	$85	17,595	$1,502,965
	Legal	450	4.9	$133	2,199	$293,155
	Sub-Total				43,988	$4,281,721
Small	IT	315	35.1	$103	11,045	$1,134,731
	Benefits	315	25.5	$85	8,033	$686,136
	Legal	315	3.2	$133	1,004	$133,831
	Sub-Total				20,081	$1,954,699
Total					108,489	$10,560,241

TABLE 2. -- *Summary of Burden*

Number of respondents (issuers and Plans)	2,327,850
Number of responses (Notices)	72,826,994
Total hour burden	328,265
Equivalent costs of total hour burden	$19,690,332
Total cost burden	$77,040,366

13. *Provide an estimate of the total annual cost burden to respondents or recordkeepers resulting from the collection of information. (Do not include the cost of any hour burden shown in Items 12 or 14).*

SBC

The Department estimates that there will be about 70.0million SBCs delivered with 493,244 going to ERISA plans and 69.5 million going to participants and annually.[4]

The Department assumes 50 percent of the SBCs going to plans would be sent electronically while 56.4 percent of SBCs would be sent electronically to plan participants.[5] Accordingly, the Department estimates that about 39.2 million SBCs would be electronically distributed and about 30.8 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 55 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 $12.4 million.

Uniform Glossary

The Department assumes that 5 percent of those who receive paper SBCs, will request glossaries in paper form (that is, about 1.5 million glossary requests).

The total cost burden to prepare and distribute the Uniform Glossaries would be $1.1 million.

Notice of Modifications

The Department assumes that issuers and plans will send notices of modifications to

4 Based on the 2015 Current Population Survey the Department estimates there are 61.3.0 million policy holders in ERISA https://www.dol.gov/sites/default/files/ebsa/researchers/data/health-and-welfare/health-insurance-coverage-bulletin-2016.pdf table 2.

5 According to data from the National Telecommunications and Information Agency (NTIA), 37.7 percent of individuals age 25 and over have access to the Internet at work. According to a Greenwald & Associates survey, 84 percent of plan participants find it acceptable to make electronic delivery the default option, which is used as the proxy for the number of participants who will not opt-out of electronic disclosure that are automatically enrolled (for a total of 31.7 percent receiving electronic disclosure at work). Additionally, the NTIA reports that 40.5 percent of individuals age 25 and over have access to the internet outside of work. According to a Pew Research Center survey, 61 percent of internet users use online banking, which is used as the proxy for the number of internet users who will affirmatively consent to receiving electronic disclosures (for a total of 24.7 percent receiving electronic disclosure outside of work). Combining the 31.7 percent who receive electronic disclosure at work with the 24.7 percent who receive electronic disclosure outside of work produces a total of 56.4 percent who will receive electronic disclosure overall.

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 56.4 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 55 cents.

The total cost burden to prepare and distribute the Notice of Modification would be $553,371.

The total annual cost burden is estimated to be $14.1 million. This burden is split evenly between the Departments of Labor and the Treasury, therefore, the DOL's share is $7.0 million.

TABLE 3..-- *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	493,244	246,622	$98,649	$0	$98,649
Upon Request			$0	$0	$0
Sub-Total	493,244	246,622	$98,625	$0	$98,649
SBC with Coverage Examples To Participants and Beneficiaries					
Upon Application or Eligibility	2,538,400	1,269,200	$507,680	$0	$507,680
			$11,649,92		$11,649,92
Upon Renewal	66,800,000	29,124,800	0	$0	0
Upon Request			$0	$0	$0
Beneficiaries Living Apart	133,000	133,000	$53,200	$73,150	$126,350
Sub-Total	69,471,400	30,527,000	12,210,800	73,150	12,283,950
Uniform			$305,270	$839,493	$1,144,763

Glossary	1,526,350	1,526,350			
Notice of Modification	1,336,000	582,496	$232,998	$320,373	$553,371
Total	72,826,994	32,882,468	12,847,694	1,233,015	14,080,733

TABLE 4.-- 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	493,244	246,622	4,110	$214,109	4,110	$214,109
Upon Request			-	$0	-	$0
Sub-Total	493,244	246,622	4,110	$214,109	4,110	$214,109
SBC with Coverage Examples To Participants and Beneficiaries						
Upon Application or Eligibility	2,538,400	1,269,200	21,153	$1,101,877	21,153	$1,101,877
Upon Renewal	66,800,000	29,124,800	485,413	$25,285,181	485,413	$25,285,181
Upon Request			-	$0	-	$0
Beneficiaries Living Apart	133,000	133,000	2,217	$115,466	2,217	$115,466
Sub-Total	69,471,400	30,527,000	508,783	$26,502,524	508,783	$26,502,524
Uniform Glossary	1,526,350	1,526,350	25,439	$1,325,126	25,439	$1,325,126
Notice of Modification	1,336,000	582,496	9,708	$505,704	9,708	$505,704

Total	72,826,994	32,882,468	548,041	28,547,463	548,041	$28,547,463

14. *Provide estimates of annualized cost to the Federal government. Also, provide a description of the method used to estimate cost, which should include quantification of hours, operational expenses (such as equipment, overhead, printing, and support staff), and any other expense that would not have been incurred without this collection of information. Agencies also may aggregate cost estimates from Items 12, 13, and 14 in a single table.*

    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 de minimis.

15. *Explain the reasons for any program changes or adjustments reporting in Items 13 or 14.*

    There are no program changes with this submission. Burden estimates have been adjusted to account for new estimates of the number of issuers, plans, participants and beneficiaries affected by the information collection, as well as updated data on labor rates and an updated assumption on the usage of electronic distribution. These updated data inputs decrease the hour burden by 103,287 hours compared with the prior submission and decrease the cost burden by $2,232,900 compared with the prior submission.

16. *For collections of information whose results will be published, outline plans for tabulation, and publication. Address any complex analytical techniques that will be used. Provide the time schedule for the entire project, including beginning and ending dates of the collection of information, completion of report, publication dates, and other actions.*

    There are no plans to publish any results.

17. *If seeking approval to not display the expiration date for OMB approval of the information collection, explain the reasons that display would be inappropriate.*

    The expiration date will be displayed.

18. *Explain each exception to the certification statement identified in Item 19, "Certification for Paperwork Reduction Act Submission,"*

    There are no exceptions to the certification statement.