

Attachment 1: Renewal notice for the individual market where coverage is being renewed outside the Exchange

[1 Date]

[2 [First Name]][Last Name]
[Address line 1]
[Address line 2] [City][State]
[Zip]]

Important: It's time to review your health coverage. **Pick a plan by [3 Date],** or we'll automatically re-enroll you in the same or similar coverage. This may change some of your costs and coverage, so review your options carefully.

Thank you for choosing [4 Issuer] for your health care needs. [5 We're here to help you prepare for Open Enrollment.]

Why am I getting this letter?

We're still offering your health coverage in [6 Year], but some details may have changed. Read this letter carefully and decide if you want to keep this plan or choose another one. Unless you take action by [7 Date], we'll automatically keep you in this plan for [8 Year].

You did not enroll in [9 Plan name] through [10 Exchange]. You won't get any financial help lowering your monthly premium or out-of-pocket costs (like deductibles, copayments, and coinsurance) unless you enroll in a plan through [11 Exchange].

- To find out if you qualify for these savings and to enroll in a plan through [12 Exchange], visit [13 Exchange website] by [14 Date].
- If you don't enroll in a plan through [15 Exchange] by [16 Date], you may not be able to do so for [17 Year], even if your finances change.

What's changing in [18 Year]?

Your new premium

- **Starting in [19 Month], your [20 estimated] monthly premium amount in [21 Plan name] will be \$[22 Dollar amount].**

Important: This is only an estimate based on current information we have. It doesn't reflect any changes to your enrollment, such as adding additional members to your coverage. You'll see your new monthly premium when you get your [23 Month] bill.

- Your [24 Current year] monthly premium amount is \$[25 Dollar amount].

Other changes

- [26 Briefly describe plan changes and/or refer to enclosed materials]
- You can review more details about your plan at [27 Issuer website] and in your [28 Year] Summary of Benefits and Coverage at [29 SBC web page].

What should I do next?

Decide if you want to enroll in [30 Plan name] outside of [31 Exchange] or choose another one.

☐ **I want to enroll in this plan outside of [32 Exchange].**

Pay the new monthly premium [33 by Date] and you'll be automatically enrolled.

☐ **I want to pick a different plan.**

[34 You can choose a different plan between [35 Dates]. Enroll by [36 Date] for coverage to start [37 Date].]

- Check with [38 Issuer] to see what other plans may be available, including whether [39 Plan name] is available on [40 Exchange].
- Visit [41 Exchange website] to see [42 Exchange] plans. Compare plans to save money and find a plan that best meets your needs and budget. Select the Plan name and ID of the plan you want to enroll in. Remember, you won't get financial help unless you qualify and enroll through [43 Exchange].

We're here to help

- Call [44 Issuer] at [45 Issuer phone number] or visit [46 Issuer website].
- Visit [47 Exchange website], or call [48 Exchange phone number] to learn more about [49 Exchange] and to see if you qualify for lower costs.
- Find in-person help from an assister, agent, or broker in your community at [50 Website]
- [51 Contact an agent or broker you've worked with before [52 like Agent/broker name]. [53 Call Agent/broker phone number].]
- [54 Call [55 Issuer phone number] to get this information in an accessible format, like large print, braille, or audio, at no cost to you.]

[56 Getting help in other languages]

[57 Insert non-discrimination notice and taglines consistent with any applicable state or federal requirements. If there are no such requirements, see required non-discrimination notice and optional taglines.]

Instructions for Attachment 1 – Renewal notice for the individual market where coverage is being renewed outside the Exchange

General instructions:

This notice must be used when coverage was purchased outside the Exchange and will be renewed outside the Exchange. It doesn't need to display the OMB control number.

Item 1. Enter the date of the notice, in format Month DD, YYYY.

Item 2. Enter the full name and address of the primary subscriber. In the individual market, the primary subscriber means the individual who purchases the policy and who is responsible for the payment of premiums.

Item 3: Enter the date by which plan selection must be made, in format Month DD, YYYY.

Item 4. Enter the issuer name.

Item 5. Enter the phrase “We’re here to help you prepare for Open Enrollment” only if the current policy is renewing on a calendar year basis. Otherwise, omit and skip to item 6.

Item 6. For calendar year plans, enter the following year, in format YYYY. For non-calendar year plans, enter the month and year, in format Month YYYY.

Item 7. Enter the date by which a plan selection must be made to avoid automatic re-enrollment, in format Month DD.

Item 8. For calendar year plans, enter the following year, in format YYYY. For non-calendar year plans, enter the month and year, in format Month YYYY.

Item 9. Enter plan name.

Item 10. Enter the Exchange name. For a Federally-facilitated Exchange, enter “Health Insurance Marketplace®.”

Item 11. Enter the Exchange name. For a Federally-facilitated Exchange, enter “Health Insurance Marketplace®.”

Item 12. Enter the Exchange name. For a Federally-facilitated Exchange, enter “Marketplace.”

Item 13. Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

Item 14. Enter the date by which a plan selection must be made, in format Month DD.

Item 15. Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

Item 16. Enter the date by which a plan selection must be made, in format Month DD.

Item 17. For calendar year plans enter the following year, in format YYYY. For non-calendar year plans, enter the phrase “until Open Enrollment.”

Item 18. For calendar year plans enter the following year, in format YYYY. For non-calendar year plans, enter the phrase “the next policy year.”

Item 19. Enter the beginning month of the following policy year.

Item 20. Include the word “estimated” if the new monthly premium for the following policy year has not yet been finalized at the time of providing the notice.

Item 21. Enter plan name

Item 22. Enter the monthly amount of premium for the enrollment group for which data are available, for the following policy year.

Item 23. Enter the month in which the enrollee will receive a bill for the actual monthly premium for the following policy year.

Item 24. If a calendar year plan, enter the current year, in format YYYY. If a non-calendar year plan, enter the word “current.”

Item 25. Enter the most recent monthly amount of premium for the enrollment group for which data are available, for the current policy year.

Item 26. List significant plan changes, including but not limited to changes in deductibles, cost sharing, metal level, covered services, eligibility, plan formulary and provider network. This section may refer to enclosed supplemental materials. Do not include the italicized instructions.

Item 27. Enter the issuer website.

Item 28. If a calendar year plan, enter the following year, in format YYYY. If a non-calendar year plan, enter the word “new.”

Item 29. Enter the SBC webpage for the applicable plan.

Item 30. Enter plan name.

Item 31. Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

Item 32. Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

Item 33. Enter “by” and due date for first premium for following policy year or omit and skip to item 34.

Item 34. Include this section for calendar year plans. For non-calendar year plans, briefly describe enrollment opportunities so individuals know when and how they can choose a different plan and skip to item 38. Under 45 CFR 147.104(b) and 155.420(d), consumers in a non-calendar year plan qualify for a special enrollment period based on a policy year that ends on a non-calendar year basis.

Item 35. Enter the beginning and end dates of the annual open enrollment period for the applicable benefit year, in format Month DD, YYYY.

Items 36 and 37. Enter the date by which a plan selection must be made and the corresponding coverage effective date, in format Month DD. For example, enter December 15 for coverage effective beginning January 1.

Item 38. Enter the issuer name.

Item 39. Enter plan name.

Item 40. Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

Item 41. Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

Item 42. Enter the Exchange name. For a Federally-facilitated Exchange, enter “Marketplace.”

Item 43. Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

Item 44. Enter the issuer name.

Item 45. Enter issuer phone number.

Item 46. Enter the issuer website.

Item 47. Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

Item 48. Enter the Exchange phone number. For a Federally-facilitated Exchange, enter “1-800-318-2596 (TTY: 1-855-889-4325).”

Item 49. Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

Item 50. Enter LocalHelp.HealthCare.gov in a State with a Federally-facilitated Exchange. In other States, enter the appropriate website.

Item 51. Include this phrase if the enrollee has previously used an agent or broker to enroll. Otherwise, omit and skip to item 54.

Item 52. Insert “like” followed by the name of the agent or broker the enrollee previously used, if known. Otherwise, omit and skip to item 54.

Item 53. Insert “Call” followed by the phone number of the agent or broker the enrollee previously used, if known. Otherwise, omit and skip to item 54.

Item 54. This sentence must be included for issuers subject to 1557 of the Affordable Care Act or other applicable Federal or State law and is otherwise encouraged to be included. If this sentence is omitted, skip to item 56.

Item 55. Enter issuer phone number and issuer TTY number.

Item 56. Insert “Getting Help in Other Languages” if adding a tagline pursuant to instruction 57. Otherwise, leave blank.

Item 57. Insert a nondiscrimination notice and taglines consistent with any applicable state or federal requirements. If there are no such applicable non-discrimination requirements, insert the following:

Health insurance issuers are prohibited from employing marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, expected length of life, degree of medical dependency, quality of life, or other health conditions.

Taglines are optional but encouraged for issuers outside the Exchange if they are not subject to language access standards under applicable Federal or State law. As a reminder, issuers covered by Section 1557 are responsible for providing timely and accurate language assistance in non-English languages, regardless of whether a tagline is provided in the language, if the provision of such language assistance is a reasonable step to provide meaningful access to an individual with limited English proficiency in the issuer's health programs or activities.¹

A non-QHP issuer offering coverage outside the Exchanges is subject to Section 1557 if any health program or activity of the issuer receives Federal financial assistance. See 45 CFR 92.2, 92.4. A QHP issuer offering plans outside of the Exchange may still have to comply with Section 1557 for its plans offered outside the Exchange if the QHP issuer is principally engaged in the provision or administration of health-related services, health-related coverage or other health-related coverage. Consequently, a QHP issuer must comply with the nondiscrimination requirements of Section 1557 for the issuer's plans offered both inside and outside the Exchanges.

If there are no such applicable tagline requirements, the following optional tagline may be inserted:

English: This notice has important information. This notice has important information about your application or coverage through [Issuer]. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call [phone number].

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0935-1254. This information collection is used by issuers in the individual market to provide notice where coverage is being renewed outside the Exchange. The time required to complete this information collection is estimated to average 20 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection and provide the notice to individuals. This information collection is mandatory (45 CFR 147.106). This is a third party disclosure, and the issue of confidentiality between third parties is out of scope for the collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850 or Russell.tips@cms.hhs.gov, Attention: Information Collections Clearance Officer.

¹ 45 CFR 92.101.

Attachment 2: Renewal notice for the individual market where coverage is being renewed in a QHP offered under the same product through the Exchange

[1 Date]

[2 [First Name]][Last Name]
[Address line 1]
[Address line 2]
[City][State][Zip]

Important: It's time to review your health coverage. **Update your [3 Exchange] application and pick a plan by [4 Date]**, or we'll automatically re-enroll you in the same or similar coverage for [5 Year]. This may change some of your costs and coverage, so review your options carefully.

Thank you for choosing [6 Issuer] for your health care needs. We're here to help you prepare for Open Enrollment.

Why am I getting this letter?

We're still offering your health coverage in [7 Year], but some details may have changed. Read this letter carefully and decide if you want to keep this plan or choose another one, then update your application with [8 Exchange].

What's changing in [9 Year]?

Your new premium

- **Starting in [10 Month], your new monthly premium amount is estimated to be \$[11 Dollar amount].**

Here's the math: Monthly premium of \$[12 Dollar amount] minus [13 Phrase or dollar amount] of possible financial help. Your actual monthly premium amount may be different because your financial help may change in [14 Year]. You'll find out your new monthly premium when you get your [15 Month] bill.

Important: This estimated monthly premium is based on current information we have for [16 Year]. It might not account for some or all changes that could impact your monthly premium, like cost changes in your area for next year, or changes to your household income or family size. To find out the actual amount of your monthly premium, update your [17 Exchange] application. For more information about updating your application, go to "What should I do next?" below.

- Your [18 Current year] monthly premium amount is \$[19 Dollar amount].

Here's the math: Monthly premium of \$[20 Dollar amount] minus \$[21 Dollar amount] of financial help you get each month.

Other changes

- [22 Briefly describe plan changes and/or refer to enclosed materials]
- You can review more details about your plan at [23 Issuer website] and in your [24 Year] Summary of Benefits and Coverage at [25 SBC web page].

What should I do next?

1. Update your [26 Exchange] application by [27 Date].

Review your [28 Exchange] application to make sure the information is still current and correct, and make any necessary updates. After you submit your updated application, you'll find out if you qualify for more or less financial help than in [29 Year]. This could mean you'll pay a lower monthly premium amount or lower out-of-pocket costs (like deductibles, copayments, and coinsurance). Plus, you might not owe money when you file your taxes.

[30 For automatic re-enrollment of consumers whose premium tax credit amount resulted in a \$0 premium in the current benefit year] **Important:** Our records show you had a \$0 monthly premium amount in [31 Year]. You must update your application to qualify for a \$0 monthly premium amount in [32 Next Year]. Depending on your updated information, your [33 Next Year] monthly premium amount could still be higher than it was in [34 Current Year].

2. Decide if you want to enroll in this plan or choose another one.

☐ I want to enroll in this plan.

Select [35 Plan name and ID] to enroll.

[36 For re-enrollment from a silver level QHP into a non-silver level QHP (except for Indian enrollees), insert: **Important:** This isn't a Silver plan in [37 Year]. This means you can't get financial help to lower your out-of-pocket costs if you stay in this plan. You must go back to [38 Exchange] and enroll in a Silver plan to find out if you qualify to get financial help. If you don't enroll in a Silver plan, any financial help you currently get to lower your out-of-pocket costs will end on December 31.]

☐ I want to pick a different plan.

You can choose a different plan between [39 Dates]. Enroll by [40 Date] for coverage to start January 1.]

Visit [41 Exchange website] to find other [42 Exchange] plans. Compare plans to save money and find one that best meets your needs and budget. Select the Plan name and ID of the plan you want to enroll in. You can also check with [43 Issuer] to find out what other plans may be available. Remember, you won't get financial help unless you qualify and enroll through [44 Exchange].

Note: If you got financial help in [45 Year] to lower your monthly premium, you must file federal income taxes and "reconcile" the premium tax credit you qualified for with the amount you used during [46 Year]. If the amounts are different, it may change the amount you owe or get back when you file your

federal income taxes. To reconcile the premium tax credit, you must complete IRS Form 8962 “Premium Tax Credit (PTC)” and include it with your federal tax return. For more information about the premium tax credit, visit: <https://www.irs.gov/affordable-care-act/individuals-and-families/the-premium-tax-credit-the-basics>.

We’re here to help

- Visit [47 Exchange website], or call [48 Exchange phone number] to learn more about [49 Exchange] and find out if you qualify for lower costs.
- Call [50 Issuer] at [51 Issuer phone number] or visit [52 Issuer website].
- Find in-person help from an assister, agent, or broker in your community at [53 Website].
- [54 Contact an agent or broker you've worked with before [55 like Agent/broker name]. [56 Call Agent/broker phone number.]]
- Call [57 Exchange phone number] to get this information in an accessible format, like large print, braille, or audio, at no cost to you.

[58 Getting help in other languages]

[59 Insert non-discrimination notice and taglines consistent with any applicable state or federal requirements. If there are no such requirements, see required non-discrimination notice and optional taglines]

Instructions for Attachment 2 – Renewal notice for the individual market where coverage is being renewed under the same product in a QHP offered through the Exchange.

General instructions:

This notice must be used when coverage was purchased through the Exchange and will be renewed under the same product through the Exchange, in accordance with 45 CFR 155.335(j). It doesn't need to display the OMB control number.

Item 1. Enter the date of the notice, in format Month DD, YYYY.

Item 2. Enter the full name and address of the primary subscriber. In the individual market, the primary subscriber means the individual who purchases the policy and who is responsible for the payment of premiums.

Item 3. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Health Insurance Marketplace®."

Item 4. Enter the date by which a plan selection must be made to avoid automatic re-enrollment, in format Month DD, YYYY

Item 5: Enter the following year, in format YYYY.

Item 6. Enter the issuer name.

Item 7. Enter the following year, in format YYYY.

Item 8. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Health Insurance Marketplace®."

Item 9. Enter the following year, in format YYYY.

Item 10. Enter the beginning month of the following benefit year.

Item 11. Enter the total monthly amount of premium for the enrollment group for which data are available for the following benefit year, minus the monthly amount of any advance payments of the premium tax credit paid on behalf of the enrollment group for which data are available.

Item 12. Enter the actual or estimated amount of monthly premium for the enrollment group for which data are available for the following benefit year.

Item 13. Enter the phrase "the same amount of financial help you're getting now" if the Exchange has not completed the annual eligibility redetermination by the time of providing the notice. If the Exchange has completed this redetermination by the time of providing the notice, enter the amount of advanced payments of the premium tax credit calculated from that redetermination.

Item 14. Enter the following year, in format YYYY.

Item 15. Enter the month in which the enrollee will receive a bill for the actual monthly payment for the following benefit year.

Item 16. Enter the benefit year from which financial information is being used to calculate the future year estimated premium amount, in format YYYY.

Item 17. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."

Item 18. Enter the current year, in format YYYY.

Item 19. Enter the most recent monthly amount of premium for the enrollment group for which data are available for the current benefit year, minus the most recent monthly amount of any advance payments of the premium tax credit paid on behalf of the enrollment group for which data are available.

Item. 20. Enter the most recent monthly amount of premium for the enrollment group for which data are available for the current benefit year.

Item 21. Enter the most recent monthly amount of any advance payments of the premium tax credit paid on behalf of the enrollment group for which data are available. If the most recent ATPC paid on behalf of the enrollment group is zero, enter 0.

Item 22. List significant plan changes, including but not limited to changes in deductibles, cost sharing, metal level, covered services, eligibility, plan formulary and provider network. For the purpose of describing plan changes, the issuer may use the current cost-sharing reductions (CSR) eligibility if it has not received the updated CSR eligibility from CMS. This section may also refer to enclosed supplemental materials. Do not include the italicized instructions.

Item 23. Enter the issuer website.

Item 24. Enter the following year, in format YYYY.

Item 25. Enter SBC web page for the applicable plan.

Item 26. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."

Item 27. Enter the date by which a plan selection must be made to avoid automatic re-enrollment, in format Month DD.

Item 28. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."

Item 29. Enter the current benefit year, in format YYYY.

Item 30. Include this paragraph if an enrollee's portion of premium after advanced payments of the premium tax credit is \$0 for the current benefit year. Otherwise, omit and skip to item 35.

Item 31. Enter the current year, in format YYYY.

Item 32. Enter the following year, in format YYYY.

Item 33. Enter the following year, in format YYYY

Item 34. Enter the current year, in format YYYY.

Item 35. Enter plan name and HIOS Plan ID of plan into which the enrollee's coverage will be renewed.

Item 36. Include this paragraph if the enrollee (except for Indian enrollees) is currently enrolled in a silver level QHP and their coverage is being renewed into a non-silver level QHP, consistent with 45 CFR 155.335(j). Otherwise, omit and skip to item 39.

Item 37. Enter the following benefit year, in format YYYY.

Item 38. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Marketplace."

Item 39. Enter the beginning and end dates of the annual open enrollment period for the applicable benefit year, in format Month DD, YYYY.

Item 40. Enter the date by which a plan selection must be made for coverage effective January 1, in format Month DD, YYYY.

Item 41. Enter the Exchange website. For a Federally-facilitated Exchange, enter "HealthCare.gov."

Item 42. Enter the Exchange name. For a Federally-facilitated Exchange, enter “Marketplace.”

Item 43. Enter the issuer name.

Item 44. Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

Items 45-46. Enter the current benefit year, in format YYYY.

Item 47. Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

Item 48. Enter the Exchange phone number. For a Federally-facilitated Exchange, enter “1-800-318-2596 (TTY: 1-855-889-4325).”

Item 49. Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

Item 50. Enter the issuer name.

Item 51. Enter the issuer phone number.

Item 52. Enter the issuer website.

Item 53. Enter LocalHelp.HealthCare.gov in a State with a Federally-facilitated Exchange. In other States, enter the appropriate website.

Item 54. Include this phrase if the enrollee has previously used an agent or broker to enroll. Otherwise, omit and skip to item 57.

Item 55. Enter “like” followed by the name of the agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 57.

Item 56. Enter “Call” followed by the phone number of agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 57.

Item 57. Enter the Exchange phone number and Exchange TTY number. For a Federally-facilitated Exchange, enter “1-800-318-2596 (TTY: 1-855-889-4325).”

Item 58. Insert “Getting Help in Other Languages” if adding a tagline pursuant to instruction item 65. Otherwise, leave blank.

Item 59. Insert a nondiscrimination notice and taglines consistent with any applicable state or federal requirements. If there are no such applicable non-discrimination requirements, insert the following:

Health insurance issuers are prohibited from employing marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, expected length of life, degree of medical dependency, quality of life, or other health conditions.

Taglines are optional but encouraged for issuers outside the Exchange if they are not subject to language access standards under applicable Federal or State law. As a reminder, issuers covered by Section 1557 are responsible for providing timely and accurate language assistance in non-English languages, regardless of whether a tagline is provided in the language, if the provision of such language assistance is a reasonable step to provide meaningful access to an individual with limited English proficiency in the issuer's health programs or activities.²

If there are no such applicable tagline requirements, the following optional tagline may be inserted:

² 45 CFR 92.101.

English: This notice has important information. This notice has important information about your application or coverage through [Issuer]. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call [phone number].

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0935-1254. This information collection is used by QHP issuers in the individual market to provide notice where coverage is being renewed in a QHP offered under the same product through the Exchange. The time required to complete this information collection is estimated to average 24 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection and provide the notice to individuals. This information collection is mandatory (45 CFR 147.106). This is a third party disclosure, and the issue of confidentiality between third parties is out of scope for the collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850 or Russell.tipples@cms.hhs.gov, Attention: Information Collections Clearance Officer.

Attachment 3: Discontinuation notice for the individual market outside the Exchange and the issuer is automatically enrolling the enrollee in a different plan outside the Exchange

[1 Date]

[2 [First Name]][Last Name]

[Address line 1]

[Address line 2]

[City][State][Zip]

Important: Your plan will no longer be offered next year. **Pick a plan by [3 Date]**, or we'll automatically enroll you in a different plan. This may change some of your costs and coverage, so review your options carefully.

Thank you for choosing [4 Issuer] for your health care needs. [5 We're here to help you prepare for Open Enrollment.]

Why am I getting this letter?

Starting [6 Date], we won't offer your current health coverage [7 in your area]. The last day of your current coverage is [8 Date]. Read this letter carefully and review your options.

What's changing in [9 Year]?

Your new plan

We found another plan that may meet your needs. If you don't pick another plan by [10 Date], we'll automatically enroll you in [11 Plan name]. Your coverage in [12 Plan name] will start in [13 Month]. For more information about picking a new plan, go to "What should I do next?" below.

If we automatically enroll you in [14 Plan name], you won't get any financial help lowering your monthly premium or out-of-pocket costs (like deductibles, copayments, and coinsurance).

- To find out if you qualify for these savings and to enroll in a plan through [15 Exchange], visit [16 Exchange website] by [17 Date].
- If you don't enroll in a plan through [18 Exchange] by [19 Date], you may not be able to do so for [20 Year], even if your finances change.

Your new premium

- **Starting in [21 Month], your [22 estimated] new monthly premium in [23 Plan name] will be \$[24 Dollar amount].**

Important: This is only an estimate based on current information we have. It doesn't reflect any changes to your enrollment, such as adding additional members to your coverage. You'll see your new monthly premium when you get your [25 Month] bill.

- Your [26 Current year] monthly premium is \$[27 Dollar amount].

Other changes

- *[28 Briefly describe plan changes and/or refer to enclosed materials]*
- You can review more details about this plan at [29 Issuer website] and in your [30 Year] Summary of Benefits and Coverage at [31 SBC web page].

If you want to pick another plan, enroll by [32 Date] to make sure you have the coverage you want.

What should I do next?

Decide if you want to enroll in [33 Plan name] outside of [34 Exchange] or choose another one.

☐ **I want to enroll in this plan outside of [35 Exchange].**

Pay the monthly premium by [36 Date] and you'll be automatically enrolled.

☐ **I want to pick a different plan.**

You can choose a different plan between [37 Dates]. Enroll by [38 Date] for coverage to start [39 Date].

Here are some ways to find other plans and enroll:

- Check with [40 Issuer] to see what other plans may be available, including whether [41 Plan name] is available on [42 Exchange].
- Visit [43 Exchange website] to find [44 Exchange] plans. Compare plans to save money and find one that best meets your needs and budget. Select the Plan name and ID of the plan you want to enroll in.
- Remember, you won't get financial help unless you qualify and enroll through [45 Exchange].

We're here to help

- Call [46 Issuer] at [47 Issuer phone number] or visit [48 Issuer website].
- Visit [49 Exchange website], or call [50 Exchange phone number] to learn more about [51 Exchange] and find out if you qualify for lower costs.
- Find in-person help from an assister, agent, or broker in your community at [52 Website].
- [53 Contact an agent or broker you've worked with before [54 like Agent/broker name]. [55 Call Agent/broker phone number].]
- [56 Call [57 Issuer phone number] to get this information in an accessible format, like large print, braille, or audio, at no cost to you.]

[58 Getting help in other languages]

[59 Insert non-discrimination notice and taglines consistent with any applicable state or federal requirements. If there are no such requirements, see required non-discrimination notice and optional taglines]

Instructions for Attachment 3 – Discontinuation notice for the individual market outside the Exchange and the issuer is automatically enrolling the enrollee in a different plan outside the Exchange

General instructions:

This notice must be used when the issuer is non-renewing coverage purchased outside the Exchange as the result of a product discontinuance, and consistent with applicable State law, automatically enrolling the enrollee in different coverage outside the Exchange. This includes non-renewals based on a product discontinuation or there no longer being any enrollee in the plan who live, resides, or works within the product's service area. It doesn't need to display the OMB control number.

Item 1. Enter the date of the notice, in format Month DD, YYYY.

Item 2. Enter the full name and address of the primary subscriber. In the individual market, the primary subscriber means the individual who purchases the policy and who is responsible for the payment of premiums.

Item 3. Enter the date by which a plan selection must be made to avoid automatic re-enrollment, in format Month DD, YYYY.

Item 4. Enter the issuer name.

Item 5. Enter the phrase "We're here to help you prepare for Open Enrollment" only if the current policy is terminating on a calendar year basis. Otherwise, omit and skip to item 6.

Item 6. For discontinuances, non-renewals, or terminations effective at the end of a calendar year, enter the following year, in format YYYY. For discontinuances, non-renewals, or terminations effective at any time other than the end of a calendar year, enter the month and year, in format Month YYYY.

Item 7. Enter the phrase "in your area" if non-renewing or terminating based on the fact that there is no longer any enrollee in the plan who live, resides, or works within the product's service area. Otherwise, omit and skip to item 8.

Item 8. Enter the last day on which the enrollee's current coverage will be remain in force, in format Month DD, YYYY.

Item 9. For discontinuances, non-renewals, or terminations effective at the end of a calendar year, enter the following year, in format YYYY. For discontinuances, non-renewals, or terminations effective at any time other than the end of a calendar year, enter the month and year, in format Month YYYY.

Item 10. The consumer qualifies for a special enrollment period based on loss of minimum essential coverage. Enter the date by which a plan selection must be made in accordance with 45 CFR 147.104(b)(4)(ii) or, if such date falls within an open enrollment period, enter the end date of the open enrollment period, in format Month DD, YYYY.

Items 11 and 12. Enter the plan name for the plan in which the enrollee will be automatically enrolled.

Item 13. Enter the first coverage month under the different plan, in format Month.

Item 14. Enter the plan name for the plan in which the enrollee will be automatically enrolled.

Item 15. Enter the Exchange name. For a Federally-facilitated Exchange, enter “Health Insurance Marketplace®.”

Item 16. Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

Item 17. Enter the date by which a plan selection must be made, in format Month DD, YYYY.

Item 18 . Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

Item 19. Enter the date by which a plan selection must be made, in format Month DD, YYYY.

Item 20 . For calendar year plans enter the following year, in format YYYY. For non-calendar year plans, enter the phrase “until Open Enrollment.”

Item 21. Enter the first month for the following policy year.

Item 22. Include the word “estimated” if the new monthly premium for the following policy year has not yet been finalized at the time of providing the notice.

Item 23. Enter the plan name for the plan in which the enrollee will be automatically enrolled.

Item 24. Enter the amount of monthly premium for the enrollment group for which data are available for the following policy year.

Item 25. Enter the month in which the enrollee will receive their bill with the actual monthly premium for the following policy year.

Item 26. If a calendar year plan, enter the current year, in format YYYY. If a non-calendar year plan, enter the word “current.”

Item 27. Enter the most recent amount of monthly premium for the enrollment group for which data are available for the current policy year.

Item 28. List significant plan changes, including but not limited to changes in deductibles, cost sharing, metal level, covered services, eligibility, plan formulary and provider network. This section may refer to enclosed supplemental materials. Do not include the italicized instructions.

Item 29. Enter the issuer website.

Item 30. For discontinuances, non-renewals, or terminations effective at the end of a calendar year, enter the following year, in format YYYY. For discontinuances, non-renewals, or terminations effective at any time other than the end of a calendar year, enter the word “new.”

Item 31. Insert SBC web page for the applicable plan.

Item 32. Enter the date by which a plan selection must be made, in format Month DD, YYYY.

Item 33. Enter the plan name for the plan in which the enrollee will be automatically enrolled.

Item 34. Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

Item 35. Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

Item 36. Enter due date for first premium for following policy year or omit and skip to item37.

Item 37. Enter the beginning and end dates of the special enrollment period for the loss of minimum essential coverage or, if such date falls within an open enrollment period, enter the end date of the open enrollment period, in format Month DD, YYYY.

Items 38 and 39. Enter the date by which a plan selection must be made and the corresponding coverage effective date that would result in no gap in coverage between the terminating coverage and the newly selected plan, in format Month DD, YYYY.

Item 40. Enter the issuer name.

Item 41. Enter the plan name for the plan in which the enrollee will be automatically enrolled.

Item 42. Enter the Exchange name. For a Federally-facilitated Exchange, enter “Marketplace.”

Item 43. Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

Item 44. Enter the Exchange name. For a Federally-facilitated Exchange, enter “Marketplace.”

Item 45. Enter the Exchange name. For a Federally-facilitated Exchange, enter “Marketplace.”

Item 46. Enter the issuer name.

Item 47. Enter issuer phone number.

Item 48. Enter the issuer website.

Item 49. Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

Item 50. Enter the Exchange phone number. For a Federally-facilitated Exchange, enter “1-800-318-2596 (TTY: 1-855-889-4325).”

Item 51. Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

Item 52. Enter LocalHelp.HealthCare.gov in a State with a Federally-facilitated Exchange. In other States, enter the appropriate website.

Item 53. Include this phrase if the enrollee has previously used an agent or broker to enroll. Otherwise, omit and skip to item56.

Item 54. Enter “like” followed by the name of the agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item56.

Item 55. Enter “call” followed by the phone number of agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item56.

Item 56. This sentence must be included for issuers subject to 1557 of the Affordable Care Act or other applicable Federal or State law and is otherwise encouraged to be included. If this sentence is omitted, skip to item58.

Item 57. Enter issuer phone number and issuer TTY number.

Item 58. Insert “Getting Help in Other Languages” if adding a tagline pursuant to instruction 59. Otherwise, leave blank.

Item 59. Insert a nondiscrimination notice and taglines consistent with any applicable state or federal requirements. If there are no such applicable non-discrimination requirements, insert the following:

Health insurance issuers are prohibited from employing marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, expected length of life, degree of medical dependency, quality of life, or other health conditions.

Taglines are optional but encouraged for issuers outside the Exchange if they are not subject to language access standards under applicable Federal or State law. As a reminder, issuers covered by Section 1557 are responsible for providing timely and accurate language assistance in non-English languages, regardless of whether a tagline is provided in the language, if the provision of such language assistance is a reasonable step to provide meaningful access to an individual with limited English proficiency in the issuer's health programs or activities.³

If there are no such applicable tagline requirements, the following optional tagline may be inserted:

English: This notice has important information. This notice has important information about your application or coverage through [Issuer]. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call [phone number].

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0935-1254. This information collection is used by issuers in the individual market outside the Exchange where coverage is discontinued and the issuer is automatically enrolling the enrollee in a different plan outside the Exchange. The time required to complete this information collection is estimated to average 8 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection and provide the notice to individuals. This information collection is mandatory (45 CFR 147.106). This is a third party disclosure, and the issue of confidentiality between third parties is out of scope for the collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850 or Russell.tips@cms.hhs.gov, Attention: Information Collections Clearance Officer.

³ 45 CFR 92.101.

Attachment 4: Notice for the individual market where coverage was in a QHP offered through the Exchange and the issuer is automatically enrolling the enrollee in a plan under a different product offered through the Exchange

[1 Date]

[2 [First Name]][Last Name]
[Address line 1]
[Address line 2] [City]
[State][Zip]

Important: Your plan will not be offered through the [3 Exchange] [4 in your area] next year. **Update your [5 Exchange] application and pick a plan by [6 Date]** or we'll automatically enroll you in a different [7 Exchange] plan. If you don't update your application, some of your costs and coverage may change, review your options carefully.

Thank you for choosing [8 Issuer] for your health care needs. [9 We're here to help you prepare for Open Enrollment].

Why am I getting this letter?

Starting [10 Date], we won't offer your current health coverage [11 in your area] [12 through the Exchange]. The last day of your current [13 Exchange] coverage is [14 Date]. Read this letter carefully and review your options, then update your application with [15 Exchange].

What's changing in [16 Year]?

Your new plan

We found another [17 Exchange] plan that may meet your needs. If you don't pick another plan by [18 Date], we'll automatically enroll you in [19 Plan name]. Your coverage in [20 Plan name] will start in [21 Month]. For more information about picking a new plan, go to "What should I do next?" below.

Your new premium

- **Starting in [22 Month], your new monthly premium amount is estimated to be: \$[23 Dollar amount].**

Here's the math: Monthly premium of \$[24 Dollar amount] minus [25 Phrase or dollar amount] of possible financial help. Your actual monthly premium amount may be different because your financial help may change [26 in Year]. You'll find out your new monthly premium when you get your [27 Month] bill.

Important: This estimated monthly premium is based on current information we have for [28 Year]. It might not account for some or all changes that could impact your monthly premium, like cost changes in your area for next year, or changes to your household income or family size. To find out the actual amount of your monthly premium, update your [29 Exchange] application. For more information about updating your application, go to "What should I do next?" below.

- Your [30 Current Year] monthly premium amount is \$[31 Dollar amount].

Here's the math: Monthly premium of \$[32 Dollar amount] minus \$[33 Dollar amount] of financial help you get each month.

Other changes

- [34 Briefly describe plan changes and/or refer to enclosed materials]
- You can review more details about this plan at [35 Issuer website] and in your [36 Year] Summary of Benefits and Coverage at [37 SBC web page].

If you want to pick another plan, enroll by [38 Date] to make sure you have the coverage you want.

What should I do next?

1. Update your [39 Exchange] application by [40 Date].

Review your [41 Exchange] application to make sure the information is still current and correct and make any necessary updates. After you submit your updated application, you'll find out if you qualify for more or less financial help [42 in Year] than you're getting now. This could mean you'll pay a lower monthly premium amount or lower out-of-pocket costs (like deductibles, copayments, and coinsurance). Plus, you might not owe money when you file your taxes.

[43 For automatic re-enrollment of consumers whose premium tax credit amount resulted in a \$0 premium in the current benefit year] **Important:** Our records show you had a \$0 monthly premium amount in [44 Year]. You must update your application to qualify for a \$0 monthly premium amount in [45 Next Year]. Depending on your updated information, your [45 Next Year] monthly premium amount could still be higher than it was in [46 Current Year].

2. Decide if you want to enroll in this plan or choose another one.

☐ I want to enroll in this plan

Select [47 Plan name and ID] to enroll.

[48 For re-enrollment from a silver level QHP into a non-silver level QHP (except for Indian enrollees), insert: **Important:** This isn't a Silver plan in [49 Year]. This means you can't get financial help to lower your out-of-pocket costs if you enroll in this plan. You must go back to [50 Exchange] and enroll in a Silver plan to find out if you qualify for financial help. If you don't enroll in a Silver plan, any financial help you currently get to lower your out-of-pocket costs will end on [51 Date].]

☐ I want to pick a different plan.

- You can choose a different plan between [52 Dates]. Enroll by [53 Date] for coverage to start [54 Date].

Visit [55 Exchange website] to find other [56 Exchange] plans. Compare plans to save money and find one that best meets your needs and budget. Select the Plan

name and ID of the plan you want to enroll in. You can also check with [57 Issuer] to find out what other plans may be available.

[58 **Important:** You may be able to keep your current coverage, but [59 in Year] it won't be offered [60 as a Silver plan] through [61 Exchange.] Remember, you won't get financial help [62 to lower your out-of-pocket costs] unless you qualify and enroll [63 in a Silver plan] through [64 Exchange].

Note: If you got financial help in [65 Year] to lower your monthly premium, you must file federal income taxes and “reconcile” the premium tax credit you qualified for with the amount you used during [66 Year]. If the amounts are different, it may change the amount you owe or get back when you file your federal income taxes. To reconcile the premium tax credit, you must complete IRS Form 8962 “Premium Tax Credit (PTC)” and include it with your federal tax return. For more information about the premium tax credit, visit: <https://www.irs.gov/affordable-care-act/individuals-and-families/the-premium-tax-credit-the-basics>

We're here to help

- Visit [67 Exchange website], or call [68 Exchange phone number] to learn more about [69 Exchange] and find out if you qualify for lower costs.
- Call [70 Issuer] at [71 Issuer phone number] or visit [72 Issuer website].
- Find in-person help from an assister, agent, or broker in your community at [73 Website].
- [74 Contact an agent or broker you've worked with before [75 like Agent/broker name]. [76 Call Agent/broker phone number].]
- Call [77 Exchange phone number] to get this information in an accessible format, like large print, braille, or audio, at no cost to you.

[78 Getting help in other languages]

[79 Insert non-discrimination notice and taglines consistent with any applicable state or federal requirements. If there are no such requirements, see required non-discrimination notice and optional taglines]

Instructions for Attachment 4 – Notice for the individual market where coverage was in a QHP offered through the Exchange and the issuer is automatically enrolling the enrollee in a plan under a different product offered through the Exchange

General instructions:

This notice must be used when the QHP enrollee's current product is not available for renewal through the Exchange (even if it remains available outside the Exchange) and the enrollee will, consistent with State law and, if applicable, 45 CFR 155.335(j), be automatically enrolled in a plan under a different product offered by the same QHP issuer through the Exchange. This notice must also be used when the enrollee's current silver level QHP is no longer available for renewal, the enrollee's current product no longer includes a silver level QHP available through the Exchange, and the enrollee will, consistent with State law and, if applicable, 45 CFR 155.335(j), be automatically re-enrolled in a silver level QHP under a different product offered by the same QHP issuer through the Exchange. It doesn't need to display the OMB control number.

Item 1. Enter the date of the notice, in format Month DD, YYYY.

Item 2. Enter the full name and address of the primary subscriber. In the individual market, the primary subscriber means the individual who purchases the policy and who is responsible for the payment of premiums.

Item 3. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Health Insurance Marketplace".

Item 4. Enter the phrase "in your area" if non-renewing or terminating based on the fact that there is no longer any enrollee in the plan who live, resides, or works within the product's service area. Otherwise, omit and skip to item 5.

Item 5. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."

Item 6. Enter the date by which a plan selection must be made to avoid automatic re-enrollment, in format Month DD, YYYY.

Item 7. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."

Item 8. Enter the issuer name.

Item 9. Enter the phrase "We're here to help you prepare for Open Enrollment" only if the current policy is terminating on a calendar year basis. Otherwise, omit and skip to item 10.

Item 10. Enter the first day on which the current plan will no longer be available, in format Month YYYY.

Item 11. Enter the phrase "in your area" if non-renewing or terminating based on the fact that there is no longer any enrollee in the plan who live, resides, or works within the product's service area.

Item 12. If issuer will not offer the enrollee's current product through the Exchange for the following benefit year, or will offer the current product through the Exchange but will not offer a Silver plan under that product and will auto-enroll the enrollee in a Silver level plan under a different product offered through the Exchange in accordance with 45 CFR 155.335(j), include the phrase "in [the Exchange]" and enter the Exchange name. For a Federally-facilitated Exchange, enter "the Marketplace." Otherwise omit and skip to item 14.

Item 13. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."

Item 14. Enter the last day on which the enrollee's current coverage will remain in force through the Exchange, in format Month DD, YYYY.

Item 15. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Marketplace."

Item 16. For discontinuances, non-renewals, or terminations effective at the end of a calendar year, enter the following benefit year, in format YYYY. For discontinuances, non-renewals, or terminations effective at any time other than the end of a calendar year, enter the month and year following the discontinuance, non-renewal, or termination in format Month YYYY.

Item 17. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."

Item 18. The consumer qualifies for a special enrollment period based on loss of minimum essential coverage. Enter the date by which a plan selection must be made in accordance with 45 CFR 155.420(b) or, if such date falls within an open enrollment period, enter the end date of the open enrollment period, in format Month DD, YYYY.

Items 19 and 20. Enter the plan name in which the enrollee will be automatically re-enrolled.

Item 21. For discontinuances, non-renewals, or terminations effective at the end of a calendar year, enter the beginning month of the following benefit year, in format Month YYYY. For discontinuances, non-renewals, or terminations effective at any time other than the end of a calendar year, enter the month following the discontinuance, non-renewal, or termination, in format Month YYYY.

Item 22. For discontinuances, non-renewals, or terminations effective at the end of a calendar year, enter the beginning month of the following benefit year. For discontinuances, non-renewals, or terminations effective at any time other than the end of a calendar year, enter the month following the discontinuance, non-renewal, or termination, in format Month YYYY.

Item 23. Enter the monthly premium for the enrollment group for which data are available for the following policy year, minus the monthly amount of any advanced payments of the premium tax credit paid on behalf of the enrollment group for which data are available.

Item 24. Enter the actual or estimated total monthly premium for the following benefit year.

Item 25. Enter the phrase "the same amount of financial help you're getting now" if the Exchange has not completed the annual eligibility redetermination by the time of providing the notice. If the Exchange has completed this redetermination by the time of providing the notice, enter the amount of advanced payments of the premium tax credit calculated from that redetermination.

Item 26. Enter the following year, in format YYYY.

Item 27. Enter the month in which the enrollee will receive a bill for the actual monthly payment for the following benefit year.

Item 28. Enter the benefit year from which financial information is being used to calculate the future year estimated premium amount, in format YYYY.

Item 29. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."

Item 30. Enter current year, in format YYYY.

Item 31. Enter the most recent amount of monthly premium for the enrollment group for which data are available for the current benefit year, minus the most recent monthly amount of any advance payments of the premium tax credit paid on behalf of the enrollment group for which data are available.

Item 32. Enter the most recent amount of monthly premium for the enrollment group for which data are available for the current benefit year.

Item 33. Enter the current year monthly amount of any advance payments of the premium tax credit paid on behalf of the enrollment group for which data are available. If the most recent APTC paid on behalf of the enrollment group is zero, enter 0.

Item 34. List significant plan changes, including but not limited to changes in deductibles, cost sharing, metal level, covered services, eligibility, plan formulary and provider network. For the purpose of describing plan changes, the issuer may use the current cost-sharing reductions (CSR) eligibility if it has not received the updated CSR eligibility from CMS. This section may also refer to enclosed supplemental materials. Do not include the italicized instructions.

Item 35. Enter the issuer website.

Item 36. For discontinuances, non-renewals, or terminations effective at the end of a calendar year, enter the following benefit year, in format YYYY. For discontinuances, non-renewals, or terminations effective at any time other than the end of a calendar year, enter the word "new."

Item 37. Enter SBC web page for the applicable plan.

Item 38. The consumer qualifies for a special enrollment period based on loss of minimum essential coverage. Enter the date by which a plan selection must be made in accordance with 45 CFR 155.420(b) or, if such date falls within an open enrollment period, enter the end date of the open enrollment period, in format Month DD, YYYY.

Item 39. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."

Item 40. Enter the date by which a plan selection must be made to avoid automatic re-enrollment, in format Month DD, YYYY.

Item 41. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."

Item 42. For discontinuances, non-renewals, or terminations effective at the end of a calendar year, enter "in" and the following benefit year, in format YYYY. For discontinuances, non-renewals, or terminations effective at any time other than the end of a calendar year, omit.

Item 43. Include this paragraph if an enrollee's portion of premium after advanced payments of the premium tax credit is \$0 for the current benefit year. Otherwise, omit and skip to item 47.

Item 44. Enter the current year, in format YYYY.

Item 45. Enter the following year, in format YYYY.

Item 46. Enter the current year, in format YYYY.

Item 47. Enter plan name and HIOS Plan ID of plan into which the enrollee will be enrolled.

Item 48. Include this paragraph if the enrollee (except for Indian enrollees) is currently enrolled in a Silver level QHP and will be re-enrolled into a non-Silver level QHP, consistent with 45 CFR 155.335(j). Otherwise, omit and skip to item 52.

Item 49. Enter the applicable benefit year, in format YYYY.

Item 50. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Marketplace."

Item 51. Enter last day of the current policy year, in format Month DD, YYYY.

Item 52. Enter the beginning and end dates of the special enrollment period for the loss of minimum essential coverage or, if such date falls within an open enrollment period, enter the end date of the open enrollment period, in format Month DD, YYYY.

Items 53 and 54. Enter the date by which a plan selection must be made and the corresponding coverage effective date that would result in no gap in coverage between the terminating coverage and the newly selected plan, in format Month DD, YYYY.

Item 55. Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

Item 56. Enter the Exchange name. For a Federally-facilitated Exchange, enter “Marketplace.”

Item 57. Enter the issuer name.

Item 58. Include this sentence only if enrollee’s current product remains available for renewal for the following benefit year, whether through or outside of the Exchange. Otherwise, omit and skip to item 62.

Item 59. For discontinuances, non-renewals, or terminations effective at the end of a calendar year, enter the following benefit year, in format YYYY. For discontinuances, non-renewals, or terminations effective at any time other than the end of a calendar year, omit.

Item 60. Include the words “as a Silver plan” if the enrollee’s current product will no longer include a Silver plan offered through the Exchange in the applicable benefit year.

Item 61. Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

Item 62. Enter the phrase “to lower your out-of-pocket costs” if you entered “as a Silver plan” in item 60. Otherwise, omit and skip to item 64.

Item 63. Enter the phrase “in a Silver plan” if you entered “as a Silver plan” in item 60. Otherwise, skip to item 65.

Item 64. Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

Item 65. Enter the current benefit year, in format YYYY.

Item 66. Enter the current benefit year, in format YYYY.

Item 67. Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

Item 68. Enter the Exchange phone number. For a Federally-facilitated Exchange, enter “1-800-318-2596 (TTY: 1-855-889-4325).”

Item 69. Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

Item 70. Enter the issuer name.

Item 71. Enter the issuer phone number.

Item 72. Enter the issuer website.

Item 73. Enter LocalHelp.HealthCare.gov in a State with a Federally-facilitated Exchange. In other States, enter the appropriate website.

Item 74. Include this phrase if the enrollee has previously used an agent or broker to enroll. Otherwise, omit and skip to item 77.

Item 75. Enter “like” followed by the name of the agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 77.

Item 76. Enter “Call” followed by the phone number of agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 77.

Item 77. Enter the Exchange phone number and the Exchange TTY number. For a Federally-facilitated Exchange, enter “1-800-318-2596 (TTY: 1-855-889-4325).”

Item 78. Insert “Getting Help in Other Languages” if adding a tagline pursuant to instruction 82. Otherwise, leave blank.

Item 79. Insert a nondiscrimination notice and taglines consistent with any applicable. state or federal requirements. If there are no such applicable non-discrimination requirements, insert the following:

Health insurance issuers are prohibited from employing marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex , expected length of life, degree of medical dependency, quality of life, or other health conditions.

Taglines are optional but encouraged for issuers outside the Exchange if they are not otherwise subject to language access standards under applicable Federal or State law. As a reminder, issuers covered by Section 1557 are responsible for providing timely and accurate language assistance in non-English languages, regardless of whether a tagline is provided in the language, if the provision of such language assistance is a reasonable step to provide meaningful access to an individual with limited English proficiency in the issuer's health programs or activities.⁴

For QHP issuers subject to Section 1557 that are principally engaged in the provision or administration of health-related services, health-related coverage or other health-related coverage, all of the issuer's operations are considered part of the health program or activity, with limited exceptions. Consequently, a QHP issuer must comply with the nondiscrimination requirements of Section 1557 for the issuer's plans offered both inside and outside the Exchanges. A non-QHP issuer offering coverage outside the Exchanges might also be subject to Section 1557 if any health program or activity of the issuer receives Federal financial assistance.

If there are no such applicable tagline requirements, the following optional tagline may be inserted:

English: This notice has important information. This notice has important information about your application or coverage through [Issuer]. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call [phone number].

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0935-1254. This information collection is used by QHP issuers in the individual market to provide notice where coverage in a QHP offered through the Exchange and the issuer is automatically enrolling the enrollee in a plan under a different product offered through the Exchange. The time required to complete this information collection is estimated to average 9 hours per response, including the time to review instructions,

⁴ 45 CFR 92.101.

search existing data resources, gather the data needed, and complete and review the information collection and provide the notice to individuals. This information collection is mandatory (45 CFR 147.106). This is a third party disclosure, and the issue of confidentiality between third parties is out of scope for the collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850 or Russell.tippes@cms.hhs.gov, Attention: Information Collections Clearance Officer.

Attachment 5: Discontinuation notice for the individual market outside the Exchange and the issuer is not automatically enrolling the enrollee in a different plan

[1 Date]

[2 [First Name]][Last Name]

[Address line 1]

[Address line 2]

[City][State][Zip]

Important: Your health coverage is ending. **Pick a different plan by [3 Date],** or you won't have health coverage in [4 Year].

Thank you for choosing [5 Issuer] for your health care needs. [6 We're here to help you prepare for Open Enrollment.]

Why am I getting this letter?

Starting [7 Date], we won't offer your current health coverage [8 in your area]. You must enroll in a new plan to keep health coverage. The last day of your current coverage is [9 Date].

Review your coverage options and pick a different plan between [10 Dates]. **Enroll in a different plan by [11 Date] to avoid a gap in your coverage.** If you don't have health coverage, you'll have to pay for all of your health care.

What should I do next?

Choose a different plan.

- Check with [12 Issuer] to see what other plans may be available. You won't get financial help unless you qualify and enroll through [13 Exchange].
- Visit [14 Exchange website] to see [15 Exchange] plans. Compare plans to save money and find one that best meets your needs and budget. Select the Plan name and ID of the plan you want to enroll in.

We're here to help

- Visit [16 Exchange website], or call [17 Exchange phone number] to learn more about [18 Exchange] and find out if you qualify for lower costs.
- Call [19 Issuer] at [20 Issuer phone number] or visit [21 Issuer website].

- Find in-person help from an assister, agent, or broker in your community at [22 Website].
- [23 Contact an agent or broker you've worked with before [24 like Agent/broker name]. [25 Call Agent/broker phone number].]
- [26 Call [27 Issuer phone number] to get this information in an accessible format, like large print, braille, or audio, at no cost to you].

[28 Getting help in other languages]

[29 Insert non-discrimination notice and taglines consistent with any applicable state or federal requirements. If there are no such requirements, see required non-discrimination notice and optional taglines]

Instructions for Attachment 5 – Discontinuation notice for the individual market outside the Exchange and the issuer is not automatically enrolling the enrollee in a different plan

General instructions:

This notice must be used when the issuer is non-renewing coverage purchased outside the Exchange based on a product discontinuation or there no longer being any enrollee in the plan who live, resides, or works within the product’s service area, and not automatically enrolling the enrollee in a different plan. It doesn’t need to display the OMB control number.

Item 1. Enter the date of the notice, in format Month DD, YYYY.

Item 2. Enter the full name and address of the primary subscriber. In the individual market, the primary subscriber means the individual who purchases the policy and who is responsible for the payment of premiums.

Item 3. The consumer qualifies for a special enrollment period based on loss of minimum essential coverage. Enter the date by which a plan selection must be made in accordance with 45 CFR 155.420(b) to avoid a gap in coverage, in format Month DD, YYYY.

Item 4. For discontinuances, non-renewals, or terminations effective at the end of a calendar year, enter the following year, in format YYYY. For discontinuances, non-renewals, or terminations effective at any time other than the end of a calendar year, enter the month and year, in format Month YYYY.

Item 5. Enter the issuer name.

Item 6. Enter the phrase “We’re here to help you prepare for Open Enrollment” only if the current policy is terminating on a calendar year basis. Otherwise, omit and skip to item 7.

Item 7. For discontinuances, non-renewals, or terminations effective at the end of a calendar year, enter the following year, in format YYYY. For discontinuances, non-renewals, or terminations effective at any time other than the end of a calendar year, enter the month and year, in format Month YYYY.

Item 8. Enter the phrase “in your area” if non-renewing or terminating based on the fact that there is no longer being any enrollee in the plan who live, resides, or works within the product’s service area. Otherwise, omit and skip to item 9.

Item 9. Enter the last day on which the enrollee’s current coverage will remain in force, in format Month DD, YYYY.

Item 10. Enter the beginning and end dates of the special enrollment period for the loss of minimum essential coverage or, if such date falls within an annual open enrollment period, enter the end date of the open enrollment period, in format Month DD, YYYY.

Item 11. The consumer qualifies for a special enrollment period based on loss of minimum essential coverage. Enter the date by which a plan selection must be made in accordance with 45 CFR 155.420(b) to avoid a gap in coverage, in format Month DD, YYYY.

Item 12. Enter the issuer name.

Item 13. Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Health Insurance Marketplace®.”

Item 14. Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

Item 15. Enter the Exchange name. For a Federally-facilitated Exchange, enter “Marketplace.”

Item 16. Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

Item 17. Enter the Exchange phone number. For a Federally-facilitated Exchange, enter “1-800-318-2596 (TTY: 1-855-889-4325).”

Item 18. Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

Item 19. Enter the issuer name.

Item 20. Enter issuer phone number.

Item 21. Enter issuer website.

Item 22. Enter LocalHelp.HealthCare.gov in a State with a Federally-facilitated Exchange. In other States, enter the appropriate website.

Item 23. Include this phrase if the enrollee has previously used an agent or broker to enroll. Otherwise, omit and skip to item 26.

Item 24. Enter “like” followed by the name of the agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 26.

Item 25. Enter “Call” followed by the phone number of agent or broker the enrollee has previously used, if known. Otherwise, omit skip to item 26.

Item 26. This sentence must be included for issuers subject to 1557 of the Affordable Care Act or other applicable Federal or State law and is otherwise encouraged to be included. If this sentence is omitted, skip to item 28.

Item 27. Enter issuer phone number and issuer TTY number.

Item 28. Insert “Getting Help in Other Languages” if adding a tagline pursuant to instruction 29. Otherwise, leave blank.

Item 29. Insert a nondiscrimination notice and taglines consistent with any applicable state or federal requirements. If there are no such applicable non-discrimination requirements, insert the following:

Health insurance issuers are prohibited from employing marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, expected length of life, degree of medical dependency, quality of life, or other health conditions.

Taglines are optional but encouraged for issuers outside the Exchange if they are not otherwise subject to language access standards under applicable Federal or State law. As a reminder, issuers covered by Section 1557 are responsible for providing timely and accurate language

assistance in non-English languages, regardless of whether a tagline is provided in the language, if the provision of such language assistance is a reasonable step to provide meaningful access to an individual with limited English proficiency in the issuer's health programs or activities.⁵

If there are no such applicable tagline requirements, the following optional tagline may be inserted:

English: This notice has important information. This notice has important information about your application or coverage through [Issuer]. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call [phone number].

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0935-1254. This information collection is used by issuers in the individual market outside the Exchange to provide notice where coverage is being discontinued and the issuer is not automatically enrolling the enrollee in a different plan. The time required to complete this information collection is estimated to average 4.5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection and provide the notice to individuals. This information collection is mandatory (45 CFR 147.106). This is a third party disclosure, and the issue of confidentiality between third parties is out of scope for the collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850 or Russell.tipps@cms.hhs.gov, Attention: Information Collections Clearance Officer.

⁵ 45 CFR 92.101.

Attachment 6: Discontinuation notice for the individual market where coverage being discontinued was in a QHP offered through the Exchange and the issuer is not automatically enrolling the enrollee in a different plan

[1 Date]

[2 [First Name]][Last Name]

[Address line 1]

[Address line 2]

[City][State][Zip]

Important: Your health coverage is ending. **Update your [3 Exchange] application and pick a different plan by [4 Date],** or you may not have health coverage in [5 Year].

Thank you for choosing [6 Issuer] for your health care needs. [7 We're here to help you prepare for Open Enrollment.]

Why am I getting this letter?

Starting [8 Date], we won't offer your current health coverage [9 in your area] [10 through the Exchange]. The last day of your current [11 Exchange] coverage is [12 Date].

Review your coverage options and pick a different plan between [13 Dates]. **Enroll in a different plan by [14 Date] to avoid a gap in your coverage.** If you don't have health coverage, you'll have to pay for all of your health care.

What should I do next?

1. Update your [15 Exchange] application by [16 Date].

Review your [17 Exchange] application to make sure the information is still current and correct and make any necessary updates. After you submit your updated application, you'll find out if you qualify for more or less financial help in [18 Year] than you're getting now. This could mean you'll pay a lower monthly premium amount or lower out-of-pocket costs (like deductibles, copayments, and coinsurance). Plus, you might not owe money when you file your taxes.

[19 *For automatic re-enrollment of consumers whose premium tax credit amount resulted in a \$0 premium in the current benefit year*] **Important:** Our records show you had a \$0 monthly premium amount in [20 Year]. You must update your application to qualify for a \$0 monthly premium amount in [21 Next Year]. Depending on your updated information, your [22 Next Year] monthly premium amount could still be higher than it was in [23 Current Year] if [24 Exchange] automatically enrolls you in a plan it picks for you.

2. Choose a different plan.

- Visit [25 Exchange website] to find other [26 Exchange] plans. Compare plans to save money and find one that best meets your needs and budget. Select the Plan name and ID of the plan you want to enroll in.

If you don't enroll in a plan on your own, [27 Exchange] may automatically enroll you in one.

- Check with [28 Issuer] to find out what other plans may be available, and if you can purchase the plan you now directly through [29 Issuer].

[30 **Important:** You may be able to keep your current coverage, but in [31 Year], it won't be offered [32 as a Silver plan] [33 through the Exchange]]. Remember, you won't get financial help [34 to lower your out-of-pockets costs] unless you qualify and enroll [35 in a Silver plan] through [36Exchange].

Note: If you got financial help in [37 Year] to lower your monthly premium, you must file federal income taxes and "reconcile" the premium tax credit you qualified for with the amount you used during [38 Year]. If the amounts are different, it may change the amount you owe or get back when you file your federal income taxes. To reconcile the premium tax credit, you must complete IRS Form 8962 "Premium Tax Credit (PTC)" and include it with your federal tax return. For more information about the premium tax credit, visit: <https://www.irs.gov/affordable-care-act/individuals-and-families/the-premium-tax-credit-the-basics>

We're here to help

- Visit [39 Exchange website], or call [40 Exchange phone number] to learn more about [41 Exchange] and find out if you qualify for lower costs.
- Call [42 Issuer] at [43 Issuer phone number] or visit [44 Issuer website].
- Find in-person help from an assister, agent, or broker in your community at [45 Website].
- [46 Contact an agent or broker you've worked with before [47 like Agent/broker name]. [48 Call [Agent/broker phone number].]
- Call [49 Exchange phone number] for a reasonable accommodation to get this information in an accessible format, like large print, braille, or audio, at no cost to you.

[50 Getting help in other languages]

[51 Insert non-discrimination notice and taglines consistent with any applicable state or federal requirements. If there are no such requirements, see required non-discrimination notice and optional taglines]

Instructions for Attachment 6 – Discontinuation notice for the individual market where coverage being discontinued was in a QHP offered through the Exchange and the issuer is not automatically enrolling the enrollee in a different plan

General instructions:

This notice must be used when the QHP enrollee's product is not available for renewal through or outside the Exchange and the issuer is not automatically enrolling the enrollee in a different plan through the Exchange. This includes non-renewals or terminations based on a product discontinuation or there no longer being any enrollee in the plan who lives, resides or works within the product's service area. This notice must also be used when the QHP enrollee's current product is not available for renewal through the Exchange but remains available for renewal outside the Exchange, and the issuer no longer has plans available for re-enrollment through the Exchange. It doesn't need to display the OMB control number.

Item 1. Enter the date of the notice, in format Month DD, YYYY.

Item 2. Enter the full name and address of the primary subscriber. In the individual market, the primary subscriber means the individual who purchases the policy and who is responsible for the payment of premiums.

Item 3: Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Health Insurance Marketplace".

Item 4. The consumer qualifies for a special enrollment period based on loss of minimum essential coverage. Enter the date by which a plan selection must be made in accordance with 45 CFR 155.420(b), in order to avoid a gap in coverage, in format Month DD, YYYY.

Item 5. For discontinuances, non-renewals, or terminations effective at the end of a calendar year, enter the following year, in format YYYY. For discontinuances, non-renewals, or terminations effective at any time other than the end of a calendar year, enter the month and year, in format Month YYYY.

Item 6. Enter the issuer name.

Item 7. Enter the phrase "We're here to help you prepare for Open Enrollment" only if the current policy is terminating on a calendar year basis. Otherwise, omit and skip to item 7.

Item 8. For discontinuances, non-renewals, or terminations effective at the end of a calendar year, enter the following year, in format YYYY. For discontinuances, non-renewals, or terminations effective at any time other than the end of a calendar year, enter the month and year, in format Month YYYY.

Item 9. Enter the phrase "in your area" if non-renewing or terminating based on the fact that there is no longer any enrollee under the plan who lives, resides, or works in the product's service area. Otherwise, omit and skip to item 9.

Item 10. Include this phrase if issuer will not offer the enrollee's current product through the Exchange for the following benefit year (even if the product remains available for renewal outside the Exchange). In such cases, for a Federally-facilitated Exchange, enter "the Health Insurance Marketplace". Otherwise omit and skip to item 11.

Item 11. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Marketplace." Note that if Item 10 isn't included, enter "the Health Insurance Marketplace". (The first instance is the full name, and subsequent references is "Marketplace".)

Item 12. Enter the last day on which the enrollee's current coverage will remain in force through the Exchange, in format Month DD, YYYY.

Item 13. Enter the beginning and end dates of the special enrollment period for the loss of minimum essential coverage or, if such date falls within an annual open enrollment period, enter the beginning and end date of the open enrollment period, in format Month DD, YYYY.

Item 14. The consumer qualifies for a special enrollment period based on loss of minimum essential coverage. Enter the date by which a plan selection must be made in accordance with 45 CFR 155.420(b), to avoid a gap in coverage, in format Month DD, YYYY.

Item 15. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."

Item 16. Enter the date by which a plan selection must be made to avoid automatic re-enrollment, in format Month DD, YYYY.

Item 17. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."

Item 18. For discontinuances, non-renewals, or terminations effective at the end of a calendar year, enter the following benefit year, in format YYYY. For discontinuances, non-renewals, or terminations effective at any time other than the end of a calendar year, omit.

Item 19. Include this paragraph if an enrollee's portion of premium after advanced payments of the premium tax credit in the current benefit year is \$0. Otherwise, omit and skip to item 25.

Item 20. Enter the current year, in format YYYY.

Item 21. Enter the following year, in format YYYY

Item 22. Enter the following year, in format YYYY

Item 23. Enter the current year, in format YYYY

Item 24. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace.".

Item 25. Enter the Exchange website. For a Federally-facilitated Exchange, enter "HealthCare.gov."

Item 26. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."

Item 27. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Marketplace."

Item 28 and Item 29. Enter the issuer name.

Item 30. Include this sentence only if the enrollee's current product remains available for renewal for the following benefit year, whether through or outside the Exchange. Otherwise, omit and skip to item 34.

Item 31. For discontinuances, non-renewals, or terminations effective at the end of a calendar year, enter the following benefit year, in format YYYY. For discontinuances, non-renewals, or terminations effective at any time other than the end of a calendar year, omit.

Item 32. Include the words "as a Silver plan" if the enrollee's current product will no longer include a Silver plan offered through the Exchange in the applicable benefit year.

Item 33. Enter the word "through" followed by the Exchange name if either the words "as a Silver" plan were entered in item 32 or the enrollee's current product remains available outside the Exchange, but no longer remains available for renewal through the Exchange. In this case, enter the Exchange name. For a Federally-facilitated Exchange, enter "the Marketplace."

Item 34. Enter the phrase "to lower your out-of-pocket costs" if the words "as a Silver plan" were entered in item 32. Otherwise, omit and skip to item 35.

Item 35. Enter the phrase “in a Silver plan” if you entered “as a Silver plan” in item 32. Otherwise, omit and skip to item 36.

Item 36. Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

Item 37. Enter the current benefit year, in format YYYY.

Item 38. Enter the current benefit year, in format YYYY.

Item 39. Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

Item 40. Enter the Exchange phone number. For a Federally-facilitated Exchange, enter “1-800-318-2596 (TTY: 1-855-889-4325).”

Item 41. Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Marketplace.”

Item 42. Enter issuer name.

Item 43. Enter issuer phone number.

Item 44. Enter issuer website.

Item 45. Enter LocalHelp.HealthCare.gov in a State with a Federally-facilitated Exchange. In other States, enter the appropriate website.

Item 46. Include this phrase if the enrollee has previously used an agent or broker to enroll. Otherwise, omit and skip to item 49.

Item 47. Enter “like” followed by the name of the agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 49.

Item 48. Enter “Call” followed by the phone number of agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 49.

Item 49. Enter the Exchange phone number and Exchange TTY number. For a Federally-facilitated Exchange, enter “1-800-318-2596 (TTY: 1-855-889-4325).”

Item 50. Insert “Getting Help in Other Languages” if adding a tagline pursuant to instruction 49. Otherwise, leave blank.

Item 51. Insert a nondiscrimination notice and taglines consistent with any state or federal requirements. If there are no such applicable non-discrimination requirements, insert the following:

Health insurance issuers are prohibited from employing marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, expected length of life, degree of medical dependency, quality of life, or other health conditions.

Taglines are optional but encouraged for issuers outside the Exchange if they are not subject to language access standards under applicable Federal or State law. As a reminder, issuers covered by Section 1557 are responsible for providing timely and accurate language assistance in non-English languages, regardless of whether a tagline is provided in the language, if the provision of such language

assistance is a reasonable step to provide meaningful access to an individual with limited English proficiency in the issuer's health programs or activities.⁶

If there are no such applicable tagline requirements, the following optional tagline may be inserted:

English: This notice has important information. This notice has important information about your application or coverage through [Issuer]. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call [phone number].

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0935-1254. This information collection is used by QHP issuers in the individual market to provide notice where coverage is being discontinued was in a QHP offered through the Exchange and the issuer is not automatically enrolling the enrollee in a different plan. The time required to complete this information collection is estimated to average 5.5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection and provide the notice to individuals. This information collection is mandatory (45 CFR 147.106). This is a third party disclosure, and the issue of confidentiality between third parties is out of scope for the collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850 or Russell.tipps@cms.hhs.gov, Attention: Information Collections Clearance Officer.

⁶ 45 CFR 92.101.