

APPENDIX 1:

Transparency in Coverage Model Notice

Instructions for the Transparency in Coverage Model Notice

The Departments of the Treasury, Labor, and Health and Human Services (the Departments) have issued the Transparency in Coverage proposed rules that would require non-grandfathered¹ group health plans and health insurance issuers in the individual and group markets to disclose certain cost-sharing information to a participant, beneficiary, or enrollee (or his or her authorized representative), in an internet-based self-service tool, via phone or in paper form, upon the individual's request. Under the proposed rules at 26 CFR 54.9815-2715A2, 29 CFR 2590.715-2715A2, and 45 CFR 147.211, a plan or issuer must provide an estimate of an individual's cost-sharing liability for a covered item or service, including the underlying information necessary to calculate the estimate. The plan or issuer also must provide a notice of required prerequisites for the item or service, and a notice explaining certain limitations that are applicable to the individual's cost-sharing liability estimate.

This model notice satisfies the notice requirements under the proposed rules with respect to prerequisites and the limitations of the cost-sharing information.² A plan or issuer may use this model notice when a participant, beneficiary, or enrollee (or his or her authorized representative) requests cost-sharing information in paper form or may incorporate the language contained in the model notice into the internet-based self-service tool. A plan or issuer may modify or add information to the model notice, provided the modification or additional information does not conflict with the information required to be provided under the final rules. While this model notice sets out one method for providing the required disclosures in plain language as required under the final rules, plans and issuers should consider what terminology is best used in the disclosures to promote consistency across the range of required disclosures and cost-sharing information.

¹ Grandfathered health plans and issuers offering grandfathered health insurance coverage may comply with the requirements of 26 CFR 54.9815-2715A2, 29 CFR 2590.716-2715A2 and 45 CFR 147.211 to satisfy the requirements of PHS Act section 2799A-4, Code section 9819, and ERISA section 719.

² 85 FR 72158, 72307 (Nov. 12, 2020).

Transparency in Coverage Model Notice [Name of Plan]

[Enter date of notice]

You are receiving this notice because you requested a cost estimate for an item or service. This notice contains important information about the cost estimate and information on the amount you may be required to pay for this item or service.

I. The Basics

What should I do with this notice?

Read this notice carefully along with the cost estimate. You may need to request a new cost estimate as you obtain new information, such as information on additional items or services you will receive as part of your diagnosis, treatment, or procedure.

What are the key terms?

1. An **Allowed Amount** is the maximum amount your health plan will pay for a covered item or service furnished by an out-of-network provider.
2. **Cost Sharing** is your share of costs for a covered item or service that you must pay (sometimes called “out-of-pocket costs”). Some examples of cost sharing are deductibles, coinsurance, and copayments. [*include this if balance billing is permitted under state law*] This term does not include other costs you may be responsible for, such as premiums, balance-billed amounts for out-of-network providers, or the cost of items or services not covered by your health plan.
3. An **Accumulated Amount** is the amount of financial responsibility you have incurred at the time a request for cost-sharing information is made, with respect to a deductible or out-of-pocket limit.
4. A **Covered Item or Service** is an item or service that your health plan will pay for, either in whole or in part, under the terms of your health plan.
5. An **Out-of-Network Provider** is a provider that does not have a contract with your plan to provide the requested items or services at pre-negotiated rates.
6. **Prerequisites** are certain requirements your health plan may impose on you or your provider so that your plan can determine whether a health care item or service, including treatment plans, prescription drugs, or durable medical equipment, is medically necessary before your plan will provide benefits for these items and services. For purposes of this estimate, prerequisites include prior authorization, concurrent review, and step-therapy or fail-first requirements.

Other common medical and insurance terms, including definitions of deductibles, coinsurance, and copayments, can be found in the Uniform Glossary of Coverage and Medical Terms ([DOL.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf](https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf)).

II. Important information about your cost estimate

This estimate is designed to provide you with information about the cost of an item or service before you receive care. However, this estimate has certain limitations that you should consider before making any decision to receive the item or service.

1. *[Include this in situations where applicable State and Federal law allow out-of-network providers to balance bill participants, beneficiaries, or enrollees.]* If you are treated by an out-of-network provider, after paying the cost-sharing amount determined by your health plan, you may still receive a bill for the difference between the amount the out-of-network provider charges for the item or service and the amount paid by your health plan for that same item or service. This is called balance billing, and this amount is not included in your cost estimate. *[This statement is not required if the State in which the item or service was furnished prohibits all out-of-network providers from balance billing for all items and services payable by the plan or issuer.]*
2. The actual charge for the item or service may be different than the cost estimate, depending on the actual care you receive. For example, if your physician provides additional services during your visit, your charges could be more than the cost estimate. This is one reason why it is important to discuss with your provider both before and during your visit which items and services you will receive and to request a new cost estimate if new information becomes available.
3. This cost estimate is not a benefit determination or guarantee of coverage for the item or service for which you requested information. For example, your plan may need to determine whether the item or service is medically necessary in your case before making a payment. You should follow your health plan's process for filing a claim for benefits and contact your health plan to help determine if there are any additional requirements that apply to you as part of that process.
4. *[Include the applicable statement below]:*

Your health plan counts copayment assistance and other third-party payments in the calculation of your accumulated amounts (such as deductible and out-of-pocket maximum amounts).

Your health plan does not count copayment assistance and other third-party payments in the calculation of your accumulated amounts (such as deductible and out-of-pocket maximum amounts).

5. *[Include if the item or service being considered may be a preventive item or service]* An in-network item or service may not be subject to cost sharing if it is billed as a preventive service.

III. Prerequisites (include the applicable portions of this section only if the item or service is subject to the prerequisite in question)

- a. [SELECT PLAN TERM: Prior Authorization, Preauthorization, Prior Approval or Precertification]

Your health plan must decide whether this item or service is medically necessary before it will cover this item or service. This is called [SELECT PLAN TERM: prior authorization, preauthorization, prior approval or precertification]. Your health plan may impose additional costs if you or your provider do not submit this item or service for [SELECT PLAN TERM: prior authorization, preauthorization, prior approval or precertification] before the item or service is provided.

- b. Concurrent Review

Your health plan may require a review during an ongoing course of treatment to determine whether the plan will continue to cover the item or service. This is called concurrent review. Your health plan may cease covering treatment if you or your provider do not submit this item or service for concurrent review within a specified time period after beginning your treatment or procedure.

- c. [SELECT PLAN TERM: Step-therapy or Fail-first requirement]

Your health plan will not pay for higher-cost therapies without evidence that certain lower-cost therapies have not been effective for you (these are known as fail-first policies or step-therapy requirements). You may be required to try a lower-cost alternative before your plan will cover this particular item or service.

IV. What if I need more information?

Contact: [Add contact information (including a phone number) for an individual or group of individuals, such as a department or office, the person can call regarding their cost-sharing liability estimate and questions.]

Paperwork Reduction Act 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 Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1429. This information collection is necessary to implement the Transparency in Coverage requirements and to ensure that plans and issuers provide individuals with clear, accurate cost-sharing information and accompanying notices regarding prerequisites and limitations. The information will be used to promote transparency, assist consumers in understanding their potential out-of-pocket costs, and support regulatory oversight of compliance with the disclosure requirements. The time required to complete this information collection is estimated to average 4 hours per response to provide notice of any required prerequisites and the limitations of the cost-sharing information made available through a self-service tool and 4,122 hours per response in order to make the notice available in paper form, including the time to review instructions, search existing data resources, gather the data needed, and review and complete the information collection. This information collection is mandatory for group health plans or health insurance issuers offering group or individual health insurance coverage, as required under 26 CFR 54.9815-2715A2, 29 CFR 2590.715-2715A2, and 45 CFR 147.211. 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, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.