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 website].

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 word "for", then 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.
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, including Section 1557 of the Patient Protection and Affordable Care Act (Section 1557). If there are no such applicable nondiscrimination 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, including Section 1557.
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.tipps@cms.hhs.gov, Attention: Information Collections Clearance Officer.