OMB Control No.: 0938-1254
Expiration Date: XX/XX/XXXX

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 plan or a plan with similar coverage for [5 Year]. This may change some of your costs and coverage, so review your options carefully. You **must** update your application for [6 Year] to get any financial help you qualify for. Visit [7 Exchange website], or call [8 Exchange phone number] to find out how you can update your application, even before Open Enrollment starts on [9 Date].

Thank you for choosing [10 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 [11 Year], but some details may have changed. Read this letter carefully and decide if you want to keep the plan you already have or choose another one. Then update your application with [12 Exchange] to get any financial help you may qualify for.

What's changing in [13 Year]?

Your new premium

- **Starting in [14 Month], your new monthly premium amount is estimated to be $[15 Dollar amount].**

  Here's the math: Monthly premium of $[16 Dollar amount] minus [17 Phrase or dollar amount] of possible financial help. Update your [18 Exchange] application as soon as possible to get any financial help you qualify for starting in [19 Month]. Your actual monthly premium amount may be different because your financial help may change in [20 Year]. You'll find out your new monthly premium when you get your [21 Month] bill. If you don't update your application, we'll automatically re-enroll you in the same plan or a plan with similar coverage, but you won't get financial help.

  Important: This estimated monthly premium is based on current information we have for [22 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 [23 Exchange] application. For more information about updating your application, go to "What should I do next?" below.

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

  Here's the math: Monthly premium of $[26 Dollar amount] minus $[27 Dollar amount] of financial help you get each month in [28 Year].

Your financial help

- If you don't update your application, we'll automatically re-enroll you in the same plan or a plan with similar coverage, but you won't get financial help.

  Here's the math: With financial help, your monthly premium is estimated to be $[29 Dollar amount]. Without financial help, your monthly premium is estimated to be $[30 Dollar amount].

Other changes

- *[31 Briefly describe plan changes and/or refer to enclosed materials]*
- You can review more details about your plan at [32 Issuer website] and in your [33 Year] Summary of Benefits and Coverage at [34 SBC web page].

What should I do next?

1. **Update your [35 Exchange] application by [36 Date].**
   Review your [37 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 [38 Year]. This could mean you'll pay a lower monthly premium amount or lower out-of-pocket costs (like deductibles, copayments, and coinsurance).

   If you got financial help in [39 Year], you must update your application. You won't get any financial help you qualify for until you update your application.

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

   ☐ **I want to enroll in this plan.**
   Select [40 Plan name and ID] to enroll.

   [41 *For re-enrollment from a silver level QHP into a non-silver level QHP (except for American Indian/Alaska Native enrollees), insert*: **Important:** This isn't a Silver plan in [42 Year]. This means you can't get extra financial help to lower your out-of-pocket costs if you stay in this plan. You must go back to [43 Exchange] and enroll in a Silver plan to find out if you qualify to get extra

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. Visit HealthCare.gov/lower-costs/save-on-out-of-pocket-costs for more information about Silver plans and extra financial help.

☐ **I want to pick a different plan.**
You can choose a different plan between [44 Dates]. Enroll by [45 Date] for coverage to start January 1.

Visit [46 Exchange website] to find other [47 Exchange] plans. Compare plans to 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 [48 Issuer] to find out what other plans may be available.
Remember, you won't get financial help unless you qualify and enroll through [49 Exchange].

Note: If you got financial help in [50 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 [51Year]. If the amounts are different, it may change the amount of money you owe or get back when you file your federal income taxes. To reconcile the premium tax credit, use Form 1095-A to complete IRS Form 8962 "Premium Tax Credit (PTC)." Then, you must include your completed Form 8962 with your federal tax return. For more information about the premium tax credit, visit IRS.gov/affordable-care-act/individuals-and-families/the-premium-tax-credit-the-basics.

We're here to help

- Visit [52 Exchange website], or call [53 Exchange phone number] to learn more about [54 Exchange] and find out if you qualify for lower costs.
- Call [55 Issuer] at [56 Issuer phone number] or visit [57 Issuer website].
- Find in-person help from an assister, agent, or broker in your community at [58 Website].
- [59 Contact an agent or broker you've worked with before [60 like Agent/broker name]. [61 Call Agent/broker phone number.]
- Call [62 Exchange phone number] to get this information in an accessible format, like large print, braille, or audio, at no cost to you.

[63 Getting help in other languages]

[66 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 following year, in format YYYY.\
Item 7. Enter the Exchange website. For a Federally-facilitated Exchange, enter "HealthCare.gov."
Item 8. Enter the Exchange phone number. For a Federally-facilitated Exchange, enter "1-800-318-2596 (TTY: 1-855-889-4325)."
Item 9. Enter the date when Open Enrollment begins, in format Month DD, YYYY.
Item 10. Enter the issuer name.
Item 11. Enter the following year, in format YYYY.
Item 12. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Health Insurance Marketplace®."
Item 13. Enter the following year, in format YYYY.
Item 14. Enter the beginning month of the following benefit year.
Item 15. 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 16. Enter the actual or estimated amount of monthly premium for the enrollment group for which data are available for the following benefit year.
Item 17. 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 18. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Health Insurance Marketplace®."
Item 19. Enter the beginning month of the following benefit year.
Item 20. Enter the following year, in format YYYY.
Item 21. Enter the month in which the enrollee will receive a bill for the actual monthly payment for the following benefit year.
Item 22. Enter the benefit year from which financial information is being used to calculate the future year estimated premium amount, in format YYYY.
Item 23. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."
Item 24. Enter the current year, in format YYYY.

Item 25. 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 26. Enter the most recent monthly amount of premium for the enrollment group for which data are available for the current benefit year.

Item 27. 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 28. Enter the current year, in format YYYY.

Item 29. 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 30. Enter the actual or estimated amount of monthly premium for the enrollment group for which data are available for the following benefit year.
Item 31. 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. Don't include the italicized instructions.
Item 32. Enter the issuer website.
Item 33. Enter the following year, in format YYYY.
Item 34. Enter SBC web page for the applicable plan.
Item 35. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."
Item 36. Enter the date by which a plan selection must be made to avoid automatic re-enrollment, in format Month DD.
Item 37. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."
Item 38. Enter the current benefit year, in format YYYY.
Item 39. Enter the current year, in format YYYY
Item 40. Enter plan name and HIOS Plan ID of plan into which the enrollee's coverage will be renewed.
Item 41. 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 44.
Item 42. Enter the following benefit year, in format YYYY.
Item 43. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Marketplace."
Item 44. Enter the beginning and end dates of the annual open enrollment period for the applicable benefit year, in format Month DD, YYYY.
Item 45. Enter the date by which a plan selection must be made for coverage effective January 1, in format Month DD, YYYY.
Item 46. Enter the Exchange website. For a Federally-facilitated Exchange, enter "HealthCare.gov."
Item 47. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."
Item 48. Enter the issuer name**.**
Item 49. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the

Marketplace."
Items 50-51. Enter the current benefit year, in format YYYY.
Item 52. Enter the Exchange website. For a Federally-facilitated Exchange, enter "HealthCare.gov."
Item 53. Enter the Exchange phone number. For a Federally-facilitated Exchange, enter "1-800-318-2596 (TTY: 1-855-889-4325)."
Item 54. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Marketplace."
Item 55. Enter the issuer name.
Item 56. Enter the issuer phone number.
Item 57. Enter the issuer website.
Item 58. Enter LocalHelp.HealthCare.gov in a State with a Federally-facilitated Exchange. In other States, enter the appropriate website.
Item 59. Include this phrase if the enrollee has previously used an agent or broker to enroll. Otherwise, omit and skip to item 62.
Item 60. Enter "like" followed by the name of the agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 62.
Item 61. Enter "Call" followed by the phone number of agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 62.
Item 62. 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 63. Insert "Getting Help in Other Languages" if adding a tagline pursuant to instruction item 64. Otherwise, leave blank.
Item 64. 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 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.tipps@cms.hhs.gov, Attention: Information Collections Clearance Officer.