

**UPDATED FEDERAL STANDARD RENEWAL AND PRODUCT  
DISCONTINUATION NOTICES IN THE INDIVIDUAL MARKET (REQUIRED  
FOR NOTICES PROVIDED IN CONNECTION WITH COVERAGE  
BEGINNING IN THE 2021 PLAN YEAR)**

**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. Take action by [3 Date], or you'll be automatically re-enrolled 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?**

Your health coverage is still being offered 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], you'll be automatically enrolled in this plan for [8 Year].

**Important:** This isn't an [9 Exchange] plan. This means you won't get any financial help lowering your monthly premium or out-of-pocket costs (like deductibles, copayments, and coinsurance) if you remain enrolled in this plan. To see if you qualify for these savings and to enroll in an [10 Exchange] plan, visit [11 Exchange website] by [12 Date]. [13 If you don't, any financial help you currently get will end in [14 Month].] If you don't enroll in an [15 Exchange] plan by [16 Date], you may not be able to switch to one for [17 Year], even if your finances change.

**Changes you'll see to your plan in [18 Year]**

**Your new premium**

- Your [19 Current year] monthly premium is \$[20 Dollar amount].
- **Starting in [21 Month], your [22 estimated] monthly premium will be \$[23 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 payment amount when you get your [24 Month] bill.

**Other changes**

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

## **What you need to do**

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

### **I want to enroll in this plan.**

Pay the new monthly premium [28 by Date] and you'll be automatically enrolled.

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

[29 You can choose a different plan between [30 Dates]. Enroll by [31 Date] for coverage to start [32 Date].]

Here are some ways to look at other plans and enroll:

- Check with [33 Issuer] to see what other plans may be available. Remember, you won't get financial help unless you qualify and enroll through [34 the Exchange].
- Visit [35 Exchange website] to see [36 Exchange] plans. Consumers who shop can save hundreds of dollars per year and can find a plan that best meets their needs and budget.

## **We're here to help**

- Call [37 Issuer] at [38 Issuer phone number] or visit [39 Issuer website].
- Visit [40 Exchange website], or call [41 Exchange phone number] to learn more about [42 the Exchange] and to see if you qualify for lower costs.
- Find in-person help from an assister, agent, or broker in your community at [43 Website]
- [44 Contact an agent or broker you've worked with before [[45 like Agent/broker name]. [46 Call Agent/broker phone number]].
- [47 Call [48 Issuer 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.

## **Getting help in other languages**

[49 *Insert non-discrimination notice and taglines consistent with any applicable standards, such as under HHS regulations and guidance.*]

### **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 0938-1254. 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. 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.

**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. Take action by [3 Date], or you'll be automatically re-enrolled 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. We're here to help you prepare for Open Enrollment.

**Why am I getting this letter?**

Your health coverage is still being offered in [5 Year], but some details may have changed. Read this letter carefully and decide if you want to keep this plan or choose another one. Also make sure to update your information with [6 the Exchange].

**Changes you'll see to your plan in [7 Year]**

**Your new premium**

- Your [8 Current year] monthly payment is \$[9 Dollar amount]. This reflects a monthly premium of \$[10 Dollar amount] minus \$[11 Dollar amount] of financial help per month.
- **Your new monthly payment (starting in [12 Month]) is estimated to be \$[13 Dollar amount].** This reflects an [14 estimated] monthly premium of \$[15 Dollar amount] minus [16 Phrase or dollar amount]. **However, your financial help may be different next year.** You'll see your new monthly payment when you receive your [17 Month] bill. **Important:** This estimated monthly payment is based on current information we have for [18 Year]. It might not account for some or all changes that could impact your monthly payment, 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 payment, update your [19 Exchange] application. See below for more information.

**Other changes**

- [20 Briefly describe plan changes and/or refer to enclosed materials]
- You can review more details about your plan at [21 Issuer website] and in your [22 Year] Summary of Benefits and Coverage.

## What you need to do

### 1. Update your [23 Exchange] application by [24 Date].

Review your [25 Exchange] application to make sure the information is still current and correct, and to see if you qualify for more or less financial help than in [26 Year]. This may result in a lower monthly premium payment or lower out-of-pocket costs (like deductibles, copayments, and coinsurance). Plus, you can help avoid paying money back when you file your taxes.

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

#### **I want to enroll in this plan.**

Update your Exchange application information, and then select [27 Plan name and ID] to enroll.

[28 For renewals from a silver level QHP into a non-silver level QHP (except for Indian enrollees)] **Important:** This isn't a Silver plan in [29 Year]. This means you can't get financial help to lower your out-of-pocket costs if you enroll in this plan. To get these savings if you qualify, you must go back to [30 the Exchange] and enroll in a Silver plan. If you don't, any financial help you currently get to lower your out-of-pocket costs will stop on December 31.]

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

You can choose a different plan between [31 Dates]. Enroll by [32 Date] for coverage to start January 1.

Here are some ways to look at other plans and enroll:

- Visit [33 Exchange website] to see other [34 Exchange] plans. Consumers who shop can save hundreds of dollars per year and can find a plan that best meets their needs and budget.
- Check with [35 Issuer] to see what other plans may be available. Remember, you won't get financial help unless you qualify and enroll through [36 the Exchange].

**Note:** If you got financial help in [37 Year] to lower your monthly premium, you'll have to "reconcile" using IRS Form 8962 when you file your federal taxes. This means you'll compare the amount of premium tax credit you received in advance during [38 Year] with the amount you actually qualify for based on your final [39 Year] household income and eligibility information. If the amounts are different, this will affect the amount of your refund or taxes owed.

## We're here to help

- Visit [40 Exchange website], or call [41 Exchange phone number] to learn more about [42 the Exchange] and to see if you qualify for lower costs.
- Call [43 Issuer] at [44 Issuer phone number] or visit [45 Issuer website].
- Find in-person help from an assister, agent, or broker in your community at [46 Website].
- [47 Contact an agent or broker you've worked with before [[48 like Agent/broker name], [49 Call Agent/broker phone number]].
- Call [50 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.

### **Getting help in other languages**

*[51 Insert non-discrimination notice and taglines consistent with any applicable standards, such as under HHS regulations and guidance.]*

### **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 0938-1254. 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. 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.

**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. Take action by [3 Date], or you'll be automatically enrolled 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?**

Beginning [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.

**Your new plan for [9 Year]**

We found another plan that may meet your needs. Starting in [10 Month], you'll be automatically enrolled in [11 Plan name].

**Important: This isn't an [12 Exchange] plan. This means you won't get any financial help lowering your monthly premium or out-of-pocket costs (like deductibles, copayments, and coinsurance) if you enroll in this plan. To see if you qualify for these savings and to enroll in an [13 Exchange] plan, visit [14 Exchange website] by [15 Date]. If you don't enroll in an [16 Exchange] plan by [17 Date], you may not be able to switch to one for [18 Year], even if your finances change.**

**Your new premium**

- Your current monthly premium is \$[19 Dollar amount].
- **Starting in [20 Month], your [21 estimated] monthly premium 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 payment amount when you get your [23 Month] bill.

**Other changes**

- [24 Briefly describe plan changes and/or refer to enclosed materials]

- You can review more details about this plan at [25 Issuer website] and in your [26 Year] Summary of Benefits and Coverage.

**If you want to pick another plan, enroll by [27 Date] to make sure you have the coverage you want. See below for more information.**

### **What you need to do**

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

#### **I want to enroll in this plan.**

Pay the monthly premium [28 by Date] and you'll be automatically enrolled.

#### **I want to pick a different plan**

You can choose a different plan between [29 Dates]. Enroll by [30 Date] for coverage to start [31 Date].

Here are some ways to look at other plans and enroll:

- Check with [32 Issuer] to see what other plans may be available.
- Visit [33 Exchange website] to see [34 Exchange] plans. Consumers who shop can save hundreds of dollars per year and can find a plan that best meets their needs and budget.

### **We're here to help**

- Call [35 Issuer] at [36 Issuer phone number] or visit [37 Issuer website].
- Visit [38 Exchange website], or call [39 Exchange phone number] to learn more about [40 the Exchange] and to see if you qualify for lower costs.
- Find in-person help from an assister, agent, or broker in your community at [41 Website].
- [42 Contact an agent or broker you've worked with before [[43 like Agent/broker name]. [44 Call [Agent/broker phone number]].
- [45 Call [46 Issuer 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.

### **Getting help in other languages**

*[47 Insert non-discrimination notice and taglines consistent with any applicable standards, such as under HHS regulations and guidance.]*

#### 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 0938-1254. 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. 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.

**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]. Take action by [5 Date] or you'll be automatically enrolled in a different [6 Exchange] plan. This may change some of your costs and coverage, so review your options carefully.

Thank you for choosing [7 Issuer] for your health care needs. [8 We're here to help you prepare for Open Enrollment].

**Why am I getting this letter?**

Beginning [9 Date], we won't offer [10 in your area] your current health coverage [11 in the Exchange]. The last day of your current [12 Exchange] coverage is [13 Date]. Read this letter carefully and review your options. Also make sure to update your information with [14 the Exchange].

**Your new plan for [15 Year]**

We found another [16 Exchange] plan that may meet your needs. Starting in [17 Month], you'll automatically be enrolled in [18 Plan name].

**Your new premium**

- Your [19 Current Year] monthly payment is \$[20 Dollar amount]. This reflects a monthly premium of \$[21 Dollar amount] minus \$[22 Dollar amount] of financial help per month.
- **Your new monthly payment (starting in [23 Month]) is estimated to be: \$[24 Dollar amount].**

This reflects an [25 estimated] monthly premium of \$[26 Dollar amount] minus [27 Phrase or dollar amount]. **However, your financial help may be different next year.** You'll see your new monthly payment when you receive your [28 Month] bill.

**Important:** This estimated monthly payment is based on current information we have for [29 Year]. It might not account for some or all changes that could impact your monthly payment, 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 payment, update your [30 Exchange] application. See below for more information.

## Other changes

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

**If you want to pick another plan, enroll by [34 Date] to make sure you have the coverage you want. See below for more information.**

## What you need to do

### 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 to see if you may qualify for more or less financial help [38 in Year] than you're getting now. This may result in a lower monthly premium payment or lower out-of-pocket costs (like deductibles, copayments, and coinsurance). Plus, you can help avoid paying money back when you file your taxes.

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

#### **I want to enroll in this plan.**

Update your Exchange application information, and then select [39 Plan name and ID] to enroll.

[40 For re-enrollment from a silver level QHP into a non-silver level QHP (except for Indian enrollees): **Important:** This isn't a Silver plan in [41 Year]. This means you can't get financial help to lower your out-of-pocket costs if you enroll in this plan. To get these savings if you qualify, you must go back to [42 the Exchange] and enroll in a Silver plan. If you don't, any financial help you currently get to lower your out-of-pocket costs will stop on [43 Date].]

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

You can choose a different plan between [44 Dates]. Enroll by [45 Date] for coverage to start [46 Date].

#### **Here are some ways to look at other plans and enroll:**

- Visit [47 Exchange website] to see other [48 Exchange] plans. Consumers who shop can save hundreds of dollars per year and can find a plan that best meets their needs and budget.
- Check with [49 Issuer] to see what other plans may be available. [[50 **Important:** You may be able to keep your current coverage, but in [51 in Year] it won't be offered [52 as a Silver plan] through [53 the Exchange.]] Remember, you won't get financial help [54 to lower your out-of-pocket costs] unless you qualify and enroll [55 in a Silver plan] through [56 the Exchange].

**Note:** If you got financial help in [57 Year] to lower your monthly premium, you'll have to "reconcile" using IRS Form 8962 when you file your federal taxes. This means you'll compare the amount of premium tax credit you received in advance during [58 Year] with the amount you actually qualify for based on your final [59 Year] household income and eligibility information. If the amounts are different, this will affect the amount of your refund or taxes owed.

### **We're here to help**

- Visit [60 Exchange website], or call [61 Exchange phone number] to learn more about [62 the Exchange] and to see if you qualify for lower costs.
- Call [63 Issuer] at [64 Issuer phone number] or visit [65 Issuer website].
- Find in-person help from an assister, agent, or broker in your community at [66 Website].
- [67 Contact an agent or broker you've worked with before [[68 like Agent/broker name]. [69 Call Agent/broker phone number]].
- Call [70 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.

### **Getting help in other languages**

*[71 Insert non-discrimination notice and taglines consistent with any applicable standards, such as under HHS regulations and guidance.]*

#### 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 0938-1254. The time required to complete this information collection is estimated to average 9 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information 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, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**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]]

**Urgent: Your health coverage is at risk.** Take action 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?**

**Beginning [7 Date], we won't offer your current health coverage [8 in your area]. This means you may lose your health coverage. You must enroll in a new plan to have health coverage.** The last day of your current coverage is [10 Date]. Read this letter carefully and review your options.

You can choose a different plan between [10 Dates]. **To make sure there isn't a gap in your coverage enroll in a different plan by [11 Date].**

**What you need to do**

Review your coverage options and pick a different plan. If you don't have health coverage, you'll have to pay for all of your health care.

Here are some ways to look at other plans and enroll:

- 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 the Exchange].
- Visit [14 Exchange website] to see [15 Exchange] plans. Consumers who shop can save hundreds of dollars per year and can find a plan that best meets their needs and budget.

**We're here to help**

- Call [16 Issuer] at [17 Issuer phone number] or visit [18 Issuer website].
- Visit [19 Exchange website], or call [20 Exchange phone number] to learn more about [21 the Exchange] and to see if you qualify for lower costs.
- 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] for a reasonable accommodation to get this information in an accessible format, like large print, Braille, or audio, at no cost to you.

### **Getting help in other languages**

*[28 Insert non-discrimination notice and taglines consistent with any applicable standards, such as under HHS regulations and guidance.]*

### **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 0938-1254. 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. 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.

**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]

**Urgent: Your health coverage is at risk.** Take action by [3 Date], or you may not 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?**

**Beginning [7 Date], we won't offer [8 in your area] your current health coverage [9 in the Exchange].** The last day of your current [10 Exchange] coverage is [11 Date]. Read this letter carefully and review your options.

You can choose a different plan between [12 Dates]. **To make sure there isn't a gap in your coverage enroll in a different plan by [13 Date].**

**What you need to do**

Review your coverage options and pick a different plan. If you don't have health coverage, you'll have to pay for all of your health care.

**1. Update your [14 Exchange] application by [15 Date].**

Review your [16 Exchange] application to make sure the information is still current and correct, and to see if you may qualify for more or less financial help [17 in Year] than you're getting now. This may result in a lower monthly premium payment or lower out-of-pocket costs (like deductibles, copayments, and coinsurance). Plus, you can help avoid paying money back when you file your taxes and reconcile your tax credit.

**2. Choose a different plan.**

Here are some ways to look at other plans and enroll:

- After you've updated your [18 Exchange] application, you'll be able to compare [19 Exchange] plans in your area. You may even see that [20 the Exchange] has picked a plan for you. Consumers who shop can save hundreds of dollars per year. Compare your options and enroll in a plan that best meets your needs and budget.

If you don't enroll in a plan on your own, you may be automatically enrolled in the plan [21 the Exchange] picked for you.

- Check with [22 Issuer] to see what other plans may be available. [23 **Important:** You may be able to keep your current coverage, but [24 in Year] it won't be offered [25 as a Silver plan][26 through the Exchange]]. Remember, you won't get financial help [27 to lower your out-of-pockets costs] unless you qualify and enroll [28 in a Silver plan] through [29 the Exchange].

**Note:** If you received financial help in [30 Year] to lower your monthly premium, you'll have to "reconcile" using IRS Form 8962 when you file your federal taxes. This means you'll compare the amount of premium tax credit you received in advance during [31 Year] with the amount you actually qualify for based on your final [32 Year] household income and eligibility information. If the amounts are different, this will affect the amount of your refund or taxes owed.

### **We're here to help**

- Visit [33 Exchange website], or call [34 Exchange phone number] to learn more about [35 the Exchange] and to see if you qualify for lower costs.
- Call [36 Issuer] at [37 Issuer phone number] or visit [38 Issuer website].
- Find in-person help from an assister, agent, or broker in your community at [39 Website].
- [40 Contact an agent or broker you've worked with before [[41 like Agent/broker name]. [42 Call [Agent/broker phone number]].
- Call [43 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.

### **Getting help in other languages**

*[44 Insert non-discrimination notice and taglines consistent with any applicable standards, such as under HHS regulations and guidance.]*

### 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 0938-1254. 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. 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.

## **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. This notice also must be used when coverage was purchased through the Exchange and will be automatically renewed outside the Exchange -- where permitted -- because the enrollee will not be automatically enrolled in another product offered through the Exchange, in accordance with 45 CFR 155.335(j).

**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 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 the Exchange name. For a Federally-facilitated Exchange, enter “Exchange.”

**Item 10.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “Exchange.”

**Item 11.** Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

**Item 12.** Enter the date by which a plan selection must be made, in format Month DD.

**Item 13.** Include this sentence only if the enrollee (i) is currently enrolled in a QHP through the Exchange; (ii) receives advanced payments of the premium tax credit or cost-sharing reductions; and (iii) will be renewed into a plan under the same product outside the Exchange, where permitted. Otherwise, omit and skip to item 15.

**Item 14.** Enter the last day of coverage through the Exchange, in format Month DD.

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

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

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

**Item 21.** Enter the beginning month of 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 monthly amount of premium for the enrollment group for which data are available, for the following policy year.

**Item 24.** Enter the month in which the enrollee will receive a bill for the actual monthly premium for the following policy year.

**Item 25.** 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 26.** Enter the issuer website.

**Item 27.** If a calendar year plan, enter the following year, in format YYYY. If a non-calendar year plan, enter the word “new.”

**Item 28.** Enter due date for first premium for following policy year or omit and skip to item 29.

**Item 29.** 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 34. 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 30.** Enter the beginning and end dates of the annual open enrollment period for the applicable benefit year, in format Month DD, YYYY.

**Items 31 and 32.** 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 33.** Enter the issuer name.

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

**Item 35.** Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

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

**Item 37.** Enter the issuer name.

**Item 38.** Enter issuer phone number.

**Item 39.** Enter the issuer website.

**Item 40.** Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

**Item 41.** Enter the Exchange phone number. For a Federally-facilitated Exchange, enter “1-800-318-2596 (TTY: 1-855-889-4325).”

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

**Item 43.** Enter LocalHelp.HealthCare.gov in a State with a Federally-facilitated Exchange. In other States, enter the appropriate website.

**Item 44.** Include this phrase if the enrollee has previously used an agent or broker to enroll. Otherwise, omit and skip to item 47.

**Item 45.** Insert “like” followed by the name of the agent or broker the enrollee previously used, if known. Otherwise, omit and skip to item 47.

**Item 46.** Insert “Call” followed by the phone number of the agent or broker the enrollee previously used, if known. Otherwise, omit and skip to item 47.

**Item 47.** 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 49.

**Item 48.** Enter issuer phone number and issuer TTY number.

**Item 49.** Insert a nondiscrimination notice and taglines consistent with any applicable standards, such as HHS regulations (e.g., the Section 1557 rule at 45 CFR 92.8 or Exchange rules at 45 CFR 155.205(c) and 156.250) and guidance.

If you are covered by Section 1557, provide the nondiscrimination notice<sup>1</sup> in English and taglines in at least the top 15 languages spoken by individuals with limited English proficiency of the relevant state or states,<sup>2</sup> in significant publications and significant communications, among other locations.<sup>3</sup> Taglines are optional but encouraged for issuers outside the Exchange if they are not covered by Section 1557 or otherwise subject to language access standards under the Exchange rules at 45 CFR 155.205(c) and 156.250, or other 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.<sup>4</sup>

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,

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<sup>1</sup> 45 CFR 92.8(a), (b)(1). The content of the notice must include the seven elements listed in 92.8(a)(1)-(7). An issuer may combine the content of the Section 1557 nondiscrimination notice with the content of other notices as long as the combined notice clearly informs individuals of their rights under Section 1557. Id. 92.8(h).

<sup>2</sup> 45 CFR 92.8(d)(1).

<sup>3</sup> 45 CFR 92.8(f)(1).

<sup>4</sup> 45 CFR 92.201.

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.

*Nondiscrimination:* [Issuer] doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age. If you think you've been discriminated against or treated unfairly for any of these reasons, you can file a complaint with the Department of Health and Human Services, Office for Civil Rights by calling 1-800-368-1019 (TTY: 1-800-537-7697), visiting [hhs.gov/ocr/civilrights/complaints](https://hhs.gov/ocr/civilrights/complaints), or writing to the Office for Civil Rights/ U.S. Department of Health and Human Services/200 Independence Avenue, SW/ Room 509F, HHH Building/ Washington, D.C. 20201.

**Sample Tagline:**

**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].

**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).

**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 following year, in format YYYY.

**Item 6.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Exchange.”

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

**Item 8.** Enter the current year, in format YYYY.

**Item 9.** 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 10.** Enter the most recent monthly amount of premium for the enrollment group for which data are available for the current benefit year.

**Item 11.** 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 12.** Enter the beginning month of the following benefit year.

**Item 13.** 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 14.** Enter the word “estimated” if the new monthly premium for the following benefit year has not yet been finalized at the time of providing the notice. Otherwise, omit, and skip to Item 15.

**Item 15.** Enter the actual or estimated amount of monthly premium for the enrollment group for which data are available for the following benefit year.

**Item 16.** 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 17.** Enter the month in which the enrollee will receive a bill for the actual monthly payment for the following benefit year.

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

**Item 19.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “Exchange.”

**Item 20.** 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 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 21.** Enter the issuer website.

**Item 22.** Enter the following year, in format YYYY.

**Item 23.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “Exchange.”

**Item 24.** Enter the date by which a plan selection must be made to avoid automatic re-enrollment, in format Month DD.

**Item 25.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “Exchange.”

**Item 26.** Enter the current benefit year, in format YYYY.

**Item 27.** Enter plan name and HIOS Plan ID of plan into which the enrollee’s coverage will be renewed.

**Item 28.** 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 31.

**Item 29.** Enter the following benefit year, in format YYYY.

**Item 30.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Exchange.”

**Item 31.** Enter the beginning and end dates of the annual open enrollment period for the applicable benefit year, in format Month DD, YYYY.

**Item 32.** Enter the date by which a plan selection must be made for coverage effective January 1, in format Month DD, YYYY.

**Item 33.** Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

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

**Item 35.** Enter the issuer name.

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

**Items– 37-39.** Enter the current benefit year, in format YYYY.

**Item 40.** Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

**Item 41.** Enter the Exchange phone number. For a Federally-facilitated Exchange, enter “1-800-318-2596 (TTY: 1-855-889-4325).”

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

**Item 43.** Enter the issuer name.

**Item 44.** Enter the issuer phone number.

**Item 45.** Enter the issuer website.

**Item 46.** Enter LocalHelp.HealthCare.gov in a State with a Federally-facilitated Exchange. In other States, enter the appropriate website.

**Item 47.** Include this phrase if the enrollee has previously used an agent or broker to enroll. Otherwise, omit and skip to item 50.

**Item 48.** Enter “like” followed by the name of the agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 50.

**Item 49.** Enter “Call” followed by the phone number of agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 50.

**Item 50.** 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 51.** Insert a nondiscrimination notice and taglines consistent with any applicable standards, such as HHS regulations (e.g., the Section 1557 rule at 45 CFR 92.8 or Exchange rules at 45 CFR 155.205(c) and 156.250) and guidance.

If you are covered by Section 1557, provide the nondiscrimination notice<sup>5</sup> in English and taglines in at least the top 15 languages spoken by individuals with limited English proficiency of the relevant state or states,<sup>6</sup> in significant publications and significant communications, among other locations.<sup>7</sup> Taglines are optional but encouraged for issuers outside the Exchange if they are not covered by Section 1557 or otherwise subject to language access standards under the Exchange rules at 45 CFR 155.205(c) and 156.250, or other 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.<sup>8</sup>

*Nondiscrimination:* [Issuer] doesn’t exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age. If you think you’ve been discriminated against or treated unfairly for any of these reasons, you can file a complaint with the Department of Health and Human Services, Office for Civil Rights by calling 1-800-368-1019 (TTY: 1-800-537-7697), visiting [hhs.gov/ocr/civilrights/complaints](https://www.hhs.gov/ocr/civilrights/complaints), or writing to the

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<sup>5</sup> 45 CFR 92.8(a), (b)(1). The content of the notice must include the seven elements listed in 92.8(a)(1)-(7). An issuer may combine the content of the Section 1557 nondiscrimination notice with the content of other notices as long as the combined notice clearly informs individuals of their rights under Section 1557. Id. 92.8(h).

<sup>6</sup> 45 CFR 92.8(d)(1).

<sup>7</sup> 45 CFR 92.8(f)(1).

<sup>8</sup> 45 CFR 92.201.

Office for Civil Rights/ U.S. Department of Health and Human Services/200 Independence Avenue, SW/ Room 509F, HHH Building/ Washington, D.C. 20201.

**Sample Tagline:**

**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].

**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.

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

**Item 11.** Enter the plan name for the plan in which the enrollee will be automatically enrolled.

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

**Item 13.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “Exchange.”

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

**Item 15.** Enter the date by which a plan selection must be made, in format Month DD.

**Item 16.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Exchange.”

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

**Item 18.** For calendar year plans enter the following year, in format YYYY. For non-calendar year plans, enter the phrase “until Open Enrollment.”

**Item 19.** Enter the most recent amount of monthly premium for the enrollment group for which data are available for the current policy year.

**Item 20.** Enter the first month for the following policy year.

**Item 21.** 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 22.** Enter the amount of monthly 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 their bill with the actual monthly premium for the following policy year.

**Item 24.** 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 25.** Enter the issuer website.

**Item 26.** 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 27.** 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 28.** Enter due date for first premium for following policy year or omit and skip to item 29.

**Item 29.** 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 30 and 31.** 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 32.** Enter the issuer name.

**Item 33.** Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

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

**Item 35.** Enter the issuer name.

**Item 36.** Enter issuer phone number.

**Item 37.** Enter the issuer website.

**Item 38.** Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

**Item 39.** Enter the Exchange phone number. For a Federally-facilitated Exchange, enter “1-800-318-2596 (TTY: 1-855-889-4325).”

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

**Item 41.** Enter LocalHelp.HealthCare.gov in a State with a Federally-facilitated Exchange. In other States, enter the appropriate website.

**Item 42.** Include this phrase if the enrollee has previously used an agent or broker to enroll. Otherwise, omit and skip to item 45.

**Item 43.** Enter “like” followed by the name of the agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 45.

**Item 44.** Enter “call” followed by the phone number of agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 45.

**Item 45.** 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 46.

**Item 46.** Enter issuer phone number and issuer TTY number.

**Item 47.** Insert a nondiscrimination notice and taglines consistent with any applicable standards, such as HHS regulations (e.g., the Section 1557 rule at 45 CFR 92.8 or Exchange rules at 45 CFR 155.205(c) and 156.250) and guidance.

If you are covered by Section 1557, provide the nondiscrimination notice<sup>9</sup> in English and taglines in at least the top 15 languages spoken by individuals with limited English proficiency of the relevant state or states,<sup>10</sup> in significant publications and significant communications, among other locations.<sup>11</sup> Taglines are optional but encouraged for issuers outside the Exchange if they are not covered by Section 1557 or otherwise subject to language access standards under the Exchange rules at 45 CFR 155.205(c) and 156.250, or other 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.<sup>12</sup>

*Nondiscrimination:* [Issuer] doesn’t exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age. If you think you’ve been discriminated against or treated unfairly for any of these reasons, you can file a complaint with the Department of Health and Human Services, Office for Civil Rights by calling 1-800-368-1019 (TTY: 1-800-537-7697), visiting [hhs.gov/ocr/civilrights/complaints](https://www.hhs.gov/ocr/civilrights/complaints), or writing to the

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<sup>9</sup> 45 CFR 92.8(a), (b)(1). The content of the notice must include the seven elements listed in 92.8(a)(1)-(7). An issuer may combine the content of the Section 1557 nondiscrimination notice with the content of other notices as long as the combined notice clearly informs individuals of their rights under Section 1557. Id. 92.8(h).

<sup>10</sup> 45 CFR 92.8(d)(1).

<sup>11</sup> 45 CFR 92.8(f)(1).

<sup>12</sup> 45 CFR 92.201.

Office for Civil Rights/ U.S. Department of Health and Human Services/200 Independence Avenue, SW/ Room 509F, HHH Building/ Washington, D.C. 20201.

**Sample Tagline:**

**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].

**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.

**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 "Exchange."

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

**Item 6.** Enter the Exchange name. For a Federally-facilitated Exchange, enter "Exchange."

**Item 7.** Enter the issuer name.

**Item 8.** 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 9.

**Item 9.** Enter the first day on which the current plan will no longer be available, in format Month YYYY.

**Item 10.** 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 11.** 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 Exchange." Otherwise omit and skip to item 13.

**Item 12.** Enter the Exchange name. For a Federally-facilitated Exchange, enter "Exchange."

**Item 13.** Enter the last day on which the enrollee’s current coverage will remain in force through the Exchange, in format Month DD, YYYY.

**Item 14.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Exchange.”

**Item 15.** 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 16.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “Exchange.”

**Item 17.** 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 18.** Enter the plan name in which the enrollee will be automatically re-enrolled.

**Item 19.** Enter current year, in format YYYY.

**Item 20.** 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 21.** Enter the most recent amount of monthly premium for the enrollment group for which data are available for the current benefit year.

**Item 22.** 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 23.** 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 24.** 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 25.** Enter the word “estimated” if the new monthly premium for the following benefit year has not yet been finalized at the time of providing the notice. Otherwise, omit and skip to Item 26.

**Item 26.** Enter the actual or estimated total monthly premium for the following benefit year.

**Item 27.** 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 28.** Enter the month in which the enrollee will receive a bill for the actual monthly payment for the following benefit year.

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

**Item 30.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “Exchange.”

**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 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 32.** Enter the issuer website.

**Item 33.** 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 34.** 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 35.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “Exchange.”

**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 “Exchange.”

**Item 38.** 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 39.** Enter plan name and HIOS Plan ID of plan into which the enrollee will be enrolled.

**Item 40.** 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 44.

**Item 41.** Enter the applicable benefit year, in format YYYY.

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

**Item 43.** Enter last day of the current policy year, in format Month DD, YYYY.

**Item 44.** 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 45 and 46.** 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 47.** Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

**Item 48.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “Exchange.”

**Item 49.** Enter the issuer name.

**Item 50.** 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 54.

**Item 51.** 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 52.** 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 53.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Exchange.”

**Item 54.** Enter the phrase “to lower your out-of-pocket costs” if you entered “as a Silver plan” in item 52. Otherwise, omit and skip to item 56.

**Item 55.** Enter the phrase “in a Silver plan” if you entered “as a Silver plan” in item 52. Otherwise, skip to item 57.

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

**Item 57.** Enter the current benefit year, in format YYYY.

**Item 58.** Enter the current benefit year, in format YYYY.

**Item 59.** Enter the current calendar year, in format YYYY.

**Item 60.** Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

**Item 61.** Enter the Exchange phone number. For a Federally-facilitated Exchange, enter “1-800-318-2596 (TTY: 1-855-889-4325).”

**Item 62.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Exchange.”

**Item 63.** Enter the issuer name.

**Item 64.** Enter the issuer phone number.

**Item 65.** Enter the issuer website.

**Item 66.** Enter LocalHelp.HealthCare.gov in a State with a Federally-facilitated Exchange. In other States, enter the appropriate website.

**Item 67.** Include this phrase if the enrollee has previously used an agent or broker to enroll. Otherwise, omit and skip to item 70.

**Item 68.** Enter “like” followed by the name of the agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 70.

**Item 69.** Enter “Call” followed by the phone number of agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 70.

**Item 70.** 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 71.** Insert a nondiscrimination notice and taglines consistent with any applicable standards, such as HHS regulations (e.g., the Section 1557 rule at 45 CFR 92.8 or Exchange rules at 45 CFR 155.205(c) and 156.250) and guidance.

If you are covered by Section 1557, provide the nondiscrimination notice<sup>13</sup> in English and taglines in at least the top 15 languages spoken by individuals with limited English proficiency of the relevant state or states,<sup>14</sup> in significant publications and significant communications, among other locations.<sup>15</sup> Taglines are optional but encouraged for issuers outside the Exchange if they are not covered by Section 1557 or otherwise subject to language access standards under the Exchange rules at 45 CFR 155.205(c) and 156.250, or other 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.<sup>16</sup>

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.

*Nondiscrimination:* [Issuer] doesn’t exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age. If you think you’ve been discriminated against or treated unfairly for any of these reasons, you can file a complaint with the Department of Health and Human Services, Office for Civil Rights by calling 1-800-368-1019 (TTY: 1-800-537-7697), visiting [hhs.gov/ocr/civilrights/complaints](https://www.hhs.gov/ocr/civilrights/complaints), or writing to the Office for Civil Rights/ U.S. Department of Health and Human Services/200 Independence Avenue, SW/ Room 509F, HHH Building/ Washington, D.C. 20201.

**Sample Tagline:**

**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].

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<sup>13</sup> 45 CFR 92.8(a), (b)(1). The content of the notice must include the seven elements listed in 92.8(a)(1)-(7). An issuer may combine the content of the Section 1557 nondiscrimination notice with the content of other notices as long as the combined notice clearly informs individuals of their rights under Section 1557. Id. 92.8(h).

<sup>14</sup> 45 CFR 92.8(d)(1).

<sup>15</sup> 45 CFR 92.8(f)(1).

<sup>16</sup> 45 CFR 92.201.

**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.

**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.

**Item 12.** Enter the issuer name.

**Item 13.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Exchange.”

**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 “Exchange.”

**Item 16.** Enter the issuer name.

**Item 17.** Enter issuer phone number.

**Item 18.** Enter issuer website.

**Item 19.** Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

**Item 20.** Enter the Exchange phone number. For a Federally-facilitated Exchange, enter “1-800-318-2596 (TTY: 1-855-889-4325).”

**Item 21.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Exchange.”

**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 a nondiscrimination notice and taglines consistent with any applicable standards, such as HHS regulations (e.g., the Section 1557 rule at 45 CFR 92.8 or Exchange rules at 45 CFR 155.205(c) and 156.250) and guidance.

If you are covered by Section 1557, provide the nondiscrimination notice<sup>17</sup> in English and taglines in at least the top 15 languages spoken by individuals with limited English proficiency of the relevant state or states,<sup>18</sup> in significant publications and significant communications, among other locations.<sup>19</sup> Taglines are optional but encouraged for issuers outside the Exchange if they are not covered by Section 1557 or otherwise subject to language access standards under the Exchange rules at 45 CFR 155.205(c) and 156.250, or other applicable Federal or State law. As a

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<sup>17</sup> 45 CFR 92.8(a), (b)(1). The content of the notice must include the seven elements listed in 92.8(a)(1)-(7). An issuer may combine the content of the Section 1557 nondiscrimination notice with the content of other notices as long as the combined notice clearly informs individuals of their rights under Section 1557. Id. 92.8(h).

<sup>18</sup> 45 CFR 92.8(d)(1).

<sup>19</sup> 45 CFR 92.8(f)(1).

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.<sup>20</sup>

*Nondiscrimination:* [Issuer] doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age. If you think you've been discriminated against or treated unfairly for any of these reasons, you can file a complaint with the Department of Health and Human Services, Office for Civil Rights by calling 1-800-368-1019 (TTY: 1-800-537-7697), visiting [hhs.gov/ocr/civilrights/complaints](https://www.hhs.gov/ocr/civilrights/complaints), or writing to the Office for Civil Rights/ U.S. Department of Health and Human Services/200 Independence Avenue, SW/ Room 509F, HHH Building/ Washington, D.C. 20201.

**Sample Tagline:**

**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].

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<sup>20</sup> 45 CFR 92.201.

**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, the issuer no longer has plans available for re-enrollment through the Exchange, and, in accordance with 45 CFR 155.335(j), the issuer is not automatically enrolling the enrollee in the enrollee’s current product outside the Exchange.

**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), in order to avoid a gap in coverage.

**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 any enrollee under the plan who lives, resides, or works in the product’s service area.

**Item 9.** 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 Exchange.” Otherwise omit and skip to item 10.

**Item 10.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Exchange.”

**Item 11.** Enter the last day on which the enrollee’s current coverage will remain in force through the Exchange, in format Month DD, YYYY.

**Item 12.** 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 13.** 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.

**Item 14.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “Exchange.”

**Item 15.** Enter the date by which a plan selection must be made to avoid automatic re-enrollment, in format Month DD.

**Item 16.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “Exchange.”

**Item 17.** 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.

**Items 18 - 19.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “Exchange.”

**Items 20 - 21.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Exchange.”

**Item 22.** Enter the issuer name.

**Item 23.** 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 27.

**Item 24.** 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 25.** 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 26.** Enter the word “through” followed by the Exchange name if either the words “as a Silver” plan were entered in item 25 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 Exchange.”

**Item 27.** Enter the phrase “to lower your out-of-pocket costs” if the words “as a Silver plan” were entered in item 25. Otherwise, omit and skip to item 29.

**Item 28.** Enter the phrase “in a Silver plan” if you entered “as a Silver plan” in item 25. Otherwise, omit and skip to item 29.

**Item 29.** Enter the Exchange name. For a Federally-facilitated Exchange, enter “the Exchange.”

**Item 30.** Enter the current benefit year, in format YYYY.

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

**Item 32.** Enter the current calendar year, in format YYYY.

**Item 33.** Enter the Exchange website. For a Federally-facilitated Exchange, enter “HealthCare.gov.”

**Item 35.** Enter the Exchange phone number. For a Federally-facilitated Exchange, enter “1-800-318-2596 (TTY: 1-855-889-4325).”

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

**Item 36.** Enter issuer name.

**Item 37.** Enter issuer phone number.

**Item 38.** Enter issuer website.

**Item 39.** Enter LocalHelp.HealthCare.gov in a State with a Federally-facilitated Exchange. In other States, enter the appropriate website.

**Item 40.** Include this phrase if the enrollee has previously used an agent or broker to enroll. Otherwise, omit and skip to item 43.

**Item 41.** Enter “like” followed by the name of the agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 43.

**Item 42.** Enter “Call” followed by the phone number of agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 43.

**Item 43.** 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 44.** Insert a nondiscrimination notice and taglines consistent with any applicable standards, such as HHS regulations (e.g., the Section 1557 rule at 45 CFR 92.8 or Exchange rules at 45 CFR 155.205(c) and 156.250) and guidance.

If you are covered by Section 1557, provide the nondiscrimination notice<sup>21</sup> in English and taglines in at least the top 15 languages spoken by individuals with limited English proficiency of the relevant state or states,<sup>22</sup> in significant publications and significant communications, among other locations.<sup>23</sup> Taglines are optional but encouraged for issuers outside the Exchange if they are not covered by Section 1557 or otherwise subject to language access standards under the Exchange rules at 45 CFR 155.205(c) and 156.250, or other 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.<sup>24</sup>

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<sup>21</sup> 45 CFR 92.8(a), (b)(1). The content of the notice must include the seven elements listed in 92.8(a)(1)-(7). An issuer may combine the content of the Section 1557 nondiscrimination notice with the content of other notices as long as the combined notice clearly informs individuals of their rights under Section 1557. Id. 92.8(h).

<sup>22</sup> 45 CFR 92.8(d)(1).

<sup>23</sup> 45 CFR 92.8(f)(1).

<sup>24</sup> 45 CFR 92.201.

*Nondiscrimination:* [Issuer] doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age. If you think you've been discriminated against or treated unfairly for any of these reasons, you can file a complaint with the Department of Health and Human Services, Office for Civil Rights by calling 1-800-368-1019 (TTY: 1-800-537-7697), visiting [hhs.gov/ocr/civilrights/complaints](https://hhs.gov/ocr/civilrights/complaints), or writing to the Office for Civil Rights/ U.S. Department of Health and Human Services/200 Independence Avenue, SW/ Room 509F, HHH Building/ Washington, D.C. 20201.

**Sample Tagline:**

**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].