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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

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Subject: Enforcement Safe Harbors related to Federal Standard Renewal and Product Discontinuation Notices; 90-Day Product Discontinuation Notice Requirement in the Individual Market

I. Purpose

The Centers for Medicare & Medicaid Services (CMS) is publishing this guidance to provide individual market qualified health plan (QHP) issuers with flexibility, if permitted by applicable state authorities, to use modified Federal standard notices of product discontinuation and renewal in connection with the open enrollment period for coverage in the 2023 benefit year, given the potentially significant changes to premiums and advance payments of the premium tax credit for the 2023 benefit year.

In addition, this guidance provides a safe harbor from enforcement by CMS, in connection with the open enrollment period for coverage in the 2023 benefit year, with respect to the requirement to provide at least 90 days' notice of a product discontinuation in the individual market, under certain conditions.

II. Enforcement Safe Harbor for Federal Standard Notices in Connection with the Open Enrollment Period for Coverage through the Individual Market Exchanges in the 2023 Benefit Year

Under guaranteed renewability requirements of title XXVII of the Public Health Service Act (PHS Act) and their implementing regulations at 45 CFR 147.106, a health insurance issuer that discontinues or renews a product[1] in the group or individual market through or outside of an Exchange (also referred to as a Health Insurance Marketplace® or Marketplace[2]) (including a renewal with uniform modifications), or that non-renews or terminates coverage in the group or individual market through or outside of an Exchange based on movement of all enrollees in a

[1] The terms "product" and "plan" are defined by regulation at 45 CFR 144.103.
[2] Health Insurance Marketplace® is a registered trademark of the U.S. Department of Health & Human Services.

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plan or policy outside the product's service area, must provide written notice in a form and manner specified by the Secretary of Health and Human Services (the Secretary).[3]

Under QHP issuer regulations at 45 CFR 156.1255, a health insurance issuer in the individual market must include certain information in the applicable renewal and discontinuation notices, including premium and advance payment of the premium tax credit information sufficient to notify the enrollment group of its expected monthly premium payment under the coverage for the upcoming policy year.[4] This regulation addresses situations in which an issuer (1) is renewing an enrollment group's coverage in a QHP offered through an Exchange (including a renewal with uniform modifications), or (2) is non-renewing or terminating coverage based on a discontinuance of the product or there no longer being any enrollee in the plan who lives, resides, or works within the product's service area, and, consistent with applicable state law, automatically enrolling an enrollee in a QHP under a different product offered by the same QHP issuer through the Exchange in accordance with 45 CFR 155.335(j).

In completing the notices, QHP issuers are instructed to inform consumers regarding their current enrollment using the most recent monthly amount of premium and most recent monthly amount of any advance payment of the premium tax credit paid on behalf of the enrollment group for which data are available. If the Exchange has completed the annual eligibility redetermination process by the time of providing the notice, QHP issuers are instructed to populate the notices with the actual amount of monthly premium for the enrollment group for the following benefit year, and the amount of advance payment of the premium tax credit calculated from that redetermination. CMS strongly encourages QHP issuers to use the actual amounts if they have the capability to do so. However, CMS recognizes that many QHP issuers begin developing their notices far in advance of when the Exchanges complete the annual eligibility redetermination, making it not possible to use the actual amounts of any advance payments of the premium tax credit for the following benefit year.

For these QHP issuers, the current version of the Federal standard notices for renewal and re-enrollment in QHPs through Exchanges[5] requires QHP issuers to notify the enrollment group of

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[3] The requirement to provide notices of renewal applies only to issuers in the individual and small group markets. The requirement to provide notices of product discontinuation and notices of non-renewal or termination based on enrollees' movement outside the service area applies to issuers in the individual, small group, and large group markets. These requirements are imposed pursuant to the PHS Act at section 2703, as added by the Patient Protection and Affordable Care Act (ACA), and sections 2712 and 2742, as added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) prior to enactment of the ACA, as codified in implementing regulations at 45 CFR 146.152, 147.106, and 148.122, respectively. For ease of reference, we refer in this guidance only to the requirements codified in section 2703 and §147.106, but references to section 2703 and §147.106 should be considered to include references to the applicable sections of all three statutes and regulations.

[4] 45 CFR 156.1255(a)-(d).

[5] See, Attachments 2 and 4, 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), available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Updated-Federal-Standard-Notices-for-coverage-beginning-in-the-2021-plan-year.pdf

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its expected monthly premium payment under the coverage for the upcoming policy year using estimates that are based on the policyholder's current plan year's premium and amount of financial help. However, because enhanced premium tax credits authorized in the American Rescue Plan of 2021 (ARP) are set to expire on December 31, 2022, basing the 2023 benefit year estimate of advance payment of the premium tax credit on the current plan year's amount of financial help will likely produce significantly inflated estimates, which have the potential to mislead consumers about the amount of financial help they will receive and their monthly premium for the 2023 benefit year. Therefore, this guidance announces enforcement discretion with respect to the Federal standard notices for renewal and re-enrollment in QHPs through Exchanges to allow issuers, if permitted by applicable state authorities, to replace the language under the heading "Your new premium" with the alternative language provided in the modified Federal notices in Attachments 1 and 2 of this guidance in connection with the open enrollment period for coverage for the 2023 benefit year.

CMS will not take enforcement action against an issuer for using the modified renewal and re-enrollment notices included in Attachment 1 and 2 of this guidance[6] in place of current Attachments 2 and 4 in the notices approved under OMB control number 0938-1254 (Annual Eligibility Redetermination, Product Discontinuation and Renewal Notices).[7] This non-enforcement policy is limited to the notices in this guidance when provided in connection with the open enrollment period for coverage in the 2023 benefit year. Issuers must continue to use the other Annual Eligibility Redetermination, Product Discontinuation and Renewal Notices when providing renewal and discontinuation notices that do not involve an enrollment or renewal in individual market coverage through the Exchange. States are encouraged to offer similar flexibility to QHP issuers. CMS will not consider a state or an Exchange to have failed to substantially enforce requirements regarding renewal and re-enrollment notices because the state adopts such an approach.

If federal legislation to extend the ARP subsidy enhancements is enacted after the date of this guidance, but before the date these notices must be sent, CMS encourages QHP issuers to use Attachments 2 and 4 of the Annual Eligibility Redetermination, Product Discontinuation and Renewal Notices, as applicable. However, CMS recognizes that many issuers begin developing their notices months in advance, and may not have the flexibility to change language in the notices at a later date. Therefore, the enforcement discretion announced in this guidance will

[6] Attachments 1 and 2 of this guidance replicate notices approved under OMB control number 0938-1254, with the exception of modified language under the heading "Your new premium," and conforming changes to the numbering of dynamic fields. CMS recognizes the instructions to the notices contain references to a now out-of-date nondiscrimination notice tagline requirement and an out-of-date description of scope of the Department's Section 1557 regulation. A nondiscrimination notice and taglines are no longer mandatory under the ACA section 1557 rule at 45 CFR 92.8. However covered entities continue to have a general obligation to provide language access under 45 CFR 92.101. The scope of coverage for Section 1557 can be found at 45 CFR 92.3.

[7] See 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), available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Updated-Federal-Standard-Notices-for-coverage-beginning-in-the-2021-plan-year.pdf.

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remain in place for the 2023 benefit year, regardless of whether legislation is enacted extending ARP subsidy enhancements.

Consistent with previous guidance, in cases where a state develops and requires the use of a different form consistent with CMS guidance, issuers in that state will be required to use notices in the form and manner specified by the state.

III. Enforcement Safe Harbor for Product Discontinuation Notices in Connection with the Open Enrollment Period for Coverage in the Individual Market in the 2023 Benefit Year

Under the guaranteed renewability provisions of the PHS Act, and the implementing regulations previously specified in this guidance, a health insurance issuer that elects to discontinue offering a particular product in the group or individual market generally must provide notice of such discontinuation at least 90 calendar days prior to the date of the discontinuation. The purpose of this requirement is to inform consumers that their current health coverage is being terminated and that they have other health coverage options.

Due to the timing of QHP certification for each of the 2015 through 2022 benefit years, issuers were in many instances unable to finalize their plan offerings until closer to the start of the annual open enrollment period, after the deadline to meet the 90-day discontinuation notice requirement. This meant consumers could potentially receive product discontinuation notices without being able to take prompt action to shop for new coverage, and issuers would not have been able to suggest replacement coverage options, as explicitly envisioned by these notices. Therefore, in connection with the open enrollment period for coverage in each of those benefit years, CMS announced that it would not take enforcement action against an issuer failing to meet the 90-day requirement in the individual market, under certain conditions.[8]

Consistent with previous guidance, in connection with the open enrollment period for coverage in the 2023 benefit year, CMS will not take enforcement action against an issuer for failing to provide a product discontinuation notice with respect to individual market coverage at least 90 days prior to the discontinuation, as long as the issuer provides such notice consistent with the timeframes applicable to renewal notices. The renewal notice timeframe for non-grandfathered, non-transitional plans[9] is before the first day of the next annual open enrollment period, and for grandfathered health plans and transitional plans is at least 60 days before the date of renewal.

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[8] For the most recent such announcement, see "Enforcement Safe Harbor for Individual Market Product Discontinuation Notices in Connection with the Open Enrollment Period for Coverage in the 2022 Benefit Year" (Sept. 1, 2021), available at https://www.cms.gov/files/document/2022-enforcement-safe-harbor-product-discontinuation-notices.pdf.

[9] For the requirements to qualify as a grandfathered plan, see 45 CFR 147.140. For the requirements to qualify as a transitional plan, sometimes known as a grandmothered plan, as well as the most recent guidance with respect to such plans, see "Insurance Standards Bulletin Series – INFORMATION – Extension of Limited Non-Enforcement Policy through 2023 and Later Benefit Years" (Mar. 23, 2022), available at

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States are encouraged to offer similar flexibility to issuers. CMS will not consider a state to have failed to substantially enforce the guaranteed renewability requirements because the state adopts such an approach.

This non-enforcement policy is limited to product discontinuations with respect to individual market coverage in connection with open enrollment; issuers must continue to provide at least 90 days' notice of a product discontinuation with respect to group market coverage, and with respect to the discontinuation of an individual market product at other times of the year.

https://www.cms.gov/files/document/extension-limited-non-enforcement-policy-through-calendar-year-2023-and-later-benefit-years.pdf.

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Attachment 1: 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 estimated monthly premium for [8 Year] wasn't available at the time we prepared this letter.** Visit [9 Exchange website] starting November 1 to get your premium amount for next year.

  If you're currently getting financial help with the cost of your health coverage, your financial help may be different in [10 Year]. **Update your [11 Exchange] application by [12 Date]** to find out how much help you qualify for next year. Get details in "What you need to do" below.

Other changes

- *[13 Briefly describe plan changes and/or refer to enclosed materials]*
- You can review more details about your plan at [14 Issuer website] and in your 15 Year] Summary of Benefits and Coverage.

What you need to do

1. **Update your [16 Exchange] application by [17 Date].**
   Review your [18 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 [19 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 [20 Plan name and ID] to enroll.

[21 *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 [22 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 [23 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 [24 Dates]. Enroll by [25 Date] for coverage to start January 1.

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

- Visit [26 Exchange website] to see other [27 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 [28 Issuer] to see what other plans may be available. Remember, you won't get financial help unless you qualify and enroll through [29 the Exchange].

Note: If you got 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.]

Instructions for Attachment 1 – 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 following year, in format YYYY.

Item 9. Enter the Exchange website. For a Federally-facilitated Exchange, enter "HealthCare.gov."

Item 10. Enter the following year, in format YYYY.

Item 11. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Exchange."

Item 12. Enter the date by which a plan selection must be made to avoid automatic re-enrollment, in format Month DD, YYYY. For a Federally-facilitated Exchange, enter December 15, 2022.

Item 13. 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 14. Enter the issuer website.

Item 15. Enter the following year, in format YYYY.

Item 16. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Exchange."

Item 17. Enter the date by which a plan selection must be made to avoid automatic re-enrollment, in format Month DD.

Item 18. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Exchange."

Item 19. Enter the current benefit year, in format YYYY.

Item 20. Enter plan name and HIOS Plan ID of plan into which the enrollee's coverage will be renewed.

Item 21. 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 24.

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

Item 23. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Exchange."

Item 24. Enter the beginning and end dates of the annual open enrollment period for the applicable benefit year, in format Month DD, YYYY.

Item 25. Enter the date by which a plan selection must be made for coverage effective January 1, in format Month DD, YYYY.

Item 26. Enter the Exchange website. For a Federally-facilitated Exchange, enter "HealthCare.gov."

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

Item 28. Enter the issuer name**.**

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

Items– 30-32. Enter the current benefit year, in format YYYY.

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

Item 34. 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 the issuer name.

Item 37. Enter the issuer phone number.

Item 38. Enter the 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[10] in English and taglines in at least the top 15 languages spoken by individuals with limited English proficiency of the relevant state or states,[11] in significant publications and significant communications, among other locations.[12] 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.[13]

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, 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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[10] 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).

[11] 45 CFR 92.8(d)(1).

[12] 45 CFR 92.8(f)(1).

[13] 45 CFR 92.201.

Attachment 2: 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 estimated monthly premium for [19 Year] wasn't available at the time we prepared this letter.** Visit [20 Exchange website] starting November 1 to get your premium amount for next year.

  If you're currently getting financial help with the cost of your health coverage, your financial help may be different in [21 Year]. **Update your [22 Exchange] application by [23 Date]** to find out how much help you qualify for next year. Get details in "What you need to do" below.

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

1. **Update your [28 Exchange] application by [29 Date].**
   Review your [30 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 [31 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 [32 Plan name and ID] to enroll.

   [33 *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 [34 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 [35 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 [36 Date].]

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

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

   - Visit [40 Exchange website] to see other [41 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 [42 Issuer] to see what other plans may be available. [[43 **Important:** You may be able to keep your current coverage, but in [44 in Year] it won't be offered [45 as a Silver plan] through [46 the Exchange.]] Remember, you won't get financial help [47 to lower your out-of-pocket costs] unless you qualify and enroll [48 in a Silver plan] through [49 the Exchange].

   Note: If you got financial help in [50 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 [51Year] with the amount you actually qualify for based on your final [52 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 [53 Exchange website], or call [54 Exchange phone number] to learn more about [55 the Exchange] and to see if you qualify for lower costs.
- Call [56 Issuer] at [57 Issuer phone number] or visit [58 Issuer website].
- Find in-person help from an assister, agent, or broker in your community at [59 Website].
- [60 Contact an agent or broker you've worked with before [[61 like Agent/broker name]. [62 Call Agent/broker phone number]].
- Call [63 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

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

Instructions for Attachment 2 – 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.

Item19. Enter the following year, in format YYYY.

Item 20. Enter the Exchange website. For a Federally-facilitated Exchange, enter "HealthCare.gov."

Item 21. Enter the following year, in format YYYY.

Item 22. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Exchange."

Item 23. Enter the date by which a plan selection must be made to avoid automatic re-enrollment, in format Month DD, YYYY. For a Federally-facilitated Exchange, enter December 15, 2022.

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. 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 25. Enter the issuer website.

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

Item 29. Enter the date by which a plan selection must be made to avoid automatic re-enrollment, in format Month DD.

Item 30. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Exchange."

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

Item 32. Enter plan name and HIOS Plan ID of plan into which the enrollee will be enrolled.

Item 33. 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 37.

Item 34. Enter the applicable benefit year, in format YYYY.

Item 35. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Exchange."

Item 36. Enter last day of the current policy year, in format Month DD, YYYY.

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

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

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

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

Item 42. Enter the issuer name.

Item 43. 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 47.

Item 44. 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 45. 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 46. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Exchange."

Item 47. Enter the phrase "to lower your out-of-pocket costs" if you entered "as a Silver plan" in item 45. Otherwise, omit and skip to item 49.

Item 48. Enter the phrase "in a Silver plan" if you entered "as a Silver plan" in item 45. Otherwise, skip to item 50.

Item 49. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Exchange."

Item 50. Enter the current benefit year, in format YYYY.

Item 51. Enter the current benefit year, in format YYYY.

Item 52. Enter the current calendar year, in format YYYY.

Item 53. Enter the Exchange website. For a Federally-facilitated Exchange, enter "HealthCare.gov."

Item 54. Enter the Exchange phone number. For a Federally-facilitated Exchange, enter "1-800-318-2596 (TTY: 1-855-889-4325)."

Item 55. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Exchange."

Item 56. Enter the issuer name.

Item 57. Enter the issuer phone number.

Item 58. Enter the issuer website.

Item 59. Enter LocalHelp.HealthCare.gov in a State with a Federally-facilitated Exchange. In other States, enter the appropriate website.

Item 60. Include this phrase if the enrollee has previously used an agent or broker to enroll. Otherwise, omit and skip to item 63.

Item 61. Enter "like" followed by the name of the agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 63.

Item 62. Enter "Call" followed by the phone number of agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 63.

Item 63. 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 64. 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[14] in English and taglines in at least the top 15 languages spoken by individuals with limited English proficiency of the relevant state or states,[15] in significant publications and significant communications, among other locations.[16] 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.[17]

[14] 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).
[15] 45 CFR 92.8(d)(1).
[16] 45 CFR 92.8(f)(1).
[17] 45 CFR 92.201.

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, 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].