DELTA DENTAL

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March 28, 2016

OMB
Office of Information and Regulatory Affairs
Attention: CMS Desk Officer
Fax Number: (202) 395-5806 / Email: OIRA_submission@omb.eop.gov

Re: CMS-10407 Summary of Benefits and Coverage Uniform Glossary

To Whom It May Concern:

On behalf of Delta Dental Plans Association (DDPA), we write in response to the Centers for Medicare & Medicaid Services' (CMS) notice regarding agency information collection activities, published in the federal register on February 26, 2016. Specifically, CMS is seeking comments on the revised Summary of Benefits and Coverage and Uniform Glossary. Copies of the revised documents were provided on CMS' Paperwork Reduction Act website.

DDPA is the nation's largest, most experienced dental benefits system. Since 1954, DDPA has worked tirelessly to improve oral health in the U.S., emphasizing preventive care by making quality, cost-effective limited-scope dental benefit plans available to a broad and diverse group of enrollees. DDPA's member companies provide a nationwide system of dental health service plans and offer custom programs and reporting systems that provide individuals, employees, and state Medicaid and CHIP participants with quality, cost-effective dental benefit programs and services. Our nationwide network of 39 companies and 155,000 dentists serves more than 68 million Americans.

Stand-alone dental plans (SADPs) are recognized as an excepted benefit and are not required to comply with the summary of benefits and coverage (SBC) requirement. 42 USC 300gg-91 (c)(2)(A). In past years, the instructions to the SBC clearly recognized that the SBC requirement does not apply to SADPs, noting, "This form does not apply to excepted benefits as defined by the Public Health Services Act (PHSA)." The templates included similar language in a footnote. We respectfully request that this language continue to be included in the instructions in the "Purpose of the form" and in a footnote in the revised templates. We have included copies of these past instructions and footnotes.

Thank you for the opportunity to comment on the revised Summary of Benefits and Coverage and Uniform Glossary. We are available to provide additional information, in writing or through discussion, on this topic.

Sincerely,

Chad Olson
Director, Government Relations

Enclosures: SBC Instructions Group 2011
SBC Instructions Individual 2011
Summary of Benefits and Coverage NPRM 2014

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What Your Plan Covers and What it Costs

Draft Instruction Guide for Group Policies

Edition Date: July 2011

Purpose of the form: Beginning in March 2012, the Patient Protection and Affordable Care Act (PPACA) requires all health insurance issuers offering group health insurance coverage to provide enrollees and potential enrollees an accurate summary of benefits and coverage explanation. This form does not apply to excepted benefits as defined by the Public Health Services Act (PHSA). Federal law requires this document so eligible employees will find it easier to compare policies and understand their coverage.

Requirements to provide/deliver the form: As set forth below, this form must be provided to the employer or eligible employees at the time of issuance of the policy or at renewal, as applicable.

While it is the insurer's, or a representative of the insurer's, responsibility to accurately fill out and deliver the form, these instructions acknowledge that eligible employees receive information about their health insurance primarily through their employer. The following are the permitted methods of delivery:

a. When an insurer, or a representative of an insurer, meets in person with the eligible employee, the insurer or a representative of the insurer may hand-deliver the completed form to the eligible employee. Alternatively, the insurer, or representative of the insurer, may offer the eligible employee the following options, and shall provide the form to be delivered in the manner selected by the eligible employee:
   1) A printed copy deposited in the United States mail, postage pre-paid, within seven (7) days of the request;
   2) An electronic copy delivered to an e-mail address provided by the eligible employee;
   3) An electronic copy delivered via a link on the Internet;
   4) A copy delivered by any other means acceptable to both the insurer and the eligible employee.

b. For an eligible employee who conducts their enrollment electronically, the insurer, or a representative of the insurer, must make the form available on the electronic site and the insurer must require the eligible employee to acknowledge receipt of the form as a necessary step to completing the enrollment application.

c. For an enrollment application that is completed over the phone or through the mail, the insurer, or a representative of the insurer, shall offer a printed copy of the completed form within seven (7) days to the address provided by the eligible employee. Alternatively, the insurer, or representative of the insurer, may offer the eligible employee the following

options, and shall provide the form to be delivered in the manner selected by the eligible employee:

1) An electronic copy delivered to an e-mail address provided by the eligible employee;
2) An electronic copy delivered via a link on the Internet;
3) A copy delivered by any other means acceptable to both the insurer and the eligible employee.

d. When an insurer issues a policy or delivers a certificate the form shall be included with the policy or certificate and provided in the manner selected by the policy holder or certificate holder.

e. When the policy or certificate is renewed, the insurer shall provide the form in the same manner in which the policy or certificate were provided along with the renewal documents.

An oral description of the form is not sufficient. An insurer, or a representative of the insurer, may not provide the form solely by orally explaining the form and its contents either in person or over the telephone.

Unless otherwise required by law, this form is a freestanding document and may not be incorporated into any other document that an insurer, or an insurer's representative, provides to an applicant, policy holder or certificate holder.

General Instructions: Read all instructions carefully before completing the form.

- This form must be filled out accurately and by the insurer in good faith.
- Form language and formatting must be precisely reproduced, unless instructions allow or instruct otherwise. Unless otherwise instructed, the insurer must use 12-point (as required by federal law) Times New Roman font, and replicate all symbols, formatting, bolding, colors, and shading exactly. Attached is an example of a blank form.
- Insurers must customize all identifiable company information throughout the document, including websites and telephone numbers.
- If there is a different amount for in-network and out-of-network expenses (such as annual deductible, additional deductibles, or out-of-pocket limits), list both amounts and indicate as such, using the terms to describe provider networks used by the insurer. For example, if the policy uses the terms "preferred provider" and "non-preferred provider" and the annual deductible is $2,000 for a preferred provider and $5,000 for a non-preferred provider, then the Answer column should show "$2000 preferred provider, $5,000 non-preferred provider".
- The items shown on Page 1 must always appear on Page 1, and the rows of the chart must always appear in the same order. The chart starting on page 2 shown in the example must always begin on Page 2, and the rows shown on this chart must always appear in the same order. However, the chart rows shown on Page 2 may extend to Page 3 if space requires, and the chart rows on Page 3 may extend to the beginning of Page 4 if space requires. The *Excluded Services and Other Covered Services* section may appear on Page 3 or Page 4, but must always immediately follow the chart starting on page 2. The

Excluded Services and Other Covered Services section must be followed by the *Your Rights to Continue Coverage* section, the *Your Grievance and Appeals Rights* section, and the *Coverage Examples* section, in that order.

- Footer: The footer must appear at the bottom left of every page. The insurer must insert the appropriate telephone number and website information.
- For initial forms (provided to employees in the pre-selection stage), insurers may provide both single and family information for each category, where applicable (e.g. premium, deductible, out-of-pocket limit and annual limit). For example, for the deductible category, the Answer column may show "$2,000 Individual" in the first line, and $3,000 Family" in the second line". For final forms (provided to employees after selection), insurers should only include information for the relevant plan.
- For all form sections to be filled out by the insurer (particularly in the *Answers* column on page 1, and the *Your Cost* and *Limitations and Exceptions* columns in the chart that starts on page 2), the insurer should use plain language and present the information in a culturally and linguistically appropriate manner and utilize terminology understandable by the average individual.

<u>Filling out the form</u>:

Top Left Header (Page 1):

On the top left hand corner of the first page, the insurer must show the following information:

- **First line:** Show the plan name and insurance company name in 16 point font and bold. Example: "**Maximum Health Plan: Alpha Insurance Group**".
    - Insurers have the option to use their logo instead of the typing in the company name if the logo includes the name of the entity issuing the coverage.
    - The insurer must use the commonly known company name.

Top Right Header (Page 1):

On the top right hand corner of the first page, the insurer must show the following information:

- **First line:** After *Policy Period*, the insurer must show the beginning and end dates for the applicable policy period in the following format: "MM/DD/YYYY – MM/DD/YYYY". For example: "Policy Period: 09/15/2010 - 09/14/2011".
- **Second line**:
    - After the words "Coverage For", indicate who the policy is for (such as Individual, Individual + Spouse, Family). The insurer will use the terms used by the policy, but should ensure that the term used will make it easy for the eligible employee to compare similar types of plans.
    - After the words "Plan Type", indicate the type of insurance plan, such as HMO, PPO, POS, Indemnity, or High-deductible.

Disclaimer (Page 1):

The disclaimer should be replicated and the insurer may not vary the font size, graphic or formatting. The insurer should insert the plan's website and telephone number.

Important Questions/Answers/ Why This Matters Chart

General Instructions for the *Important Questions* chart:

- This chart must always appear on Page 1, and the rows must always appear in the same order. Insurers must complete the *Answers* column for each question on this chart, using the instructions below.
- Insurers must show the appropriate language in the *Why This Matters* box as instructed in the instructions below. Insurers must replicate the language given for the *Why This Matters* box exactly, and may not alter the language.
- When responding with a list of items, use words such as "and", "or", or "plus" rather than using a semi-colon. For example: "Yes, $5,000 deductible for prescription drugs and $2,000 for occupational therapy" rather than "Yes, $5,000 for prescription drugs; $2,000 for occupational therapy".

1. What Is The Premium?:

Answers column:

a. Instructions for the Initial Form (provided before the employee selects a plan):

1) Insurers will include the following statement: "Please contact your employer for your share of the premium amount."

2) Employers will provide an addendum that defines the monthly premiums for each coverage level for each plan to support the evaluation of plans by eligible employees during the open enrollment period. This addendum should include the following premium information:

a) For small groups whose premiums are based on table rates, the complete rate table should be attached with a reference in the Premium box to refer to the attached rates. This will allow eligible employees to identify the premiums they would pay based on their combination of age, gender, and coverage level/tier.

b) For groups whose premiums are not based on age factors, premiums for each coverage level/tier available for the plan should be displayed. This will allow eligible employees to identify the premiums they would pay based on their coverage level/tier.

b. Final Form for Group Plans (provided after the employee selects a plan)

1) Insurers will include the following statement: "Please contact your employer for your share of the premium amount."

2) Employers will provide an addendum with the following premium information:

a) For small groups whose premiums are based on table rates, the premiums they will pay based on their combination of age, gender, and coverage level/tier should be displayed. For example: Male/Female, Age xx – xx, Coverage Tier - $xxx per month

b) For groups whose premiums are not based on age factors, premiums for each coverage level/tier available for the plan should be displayed. This will allow eligible employees to identify the

premiums they would pay based on their coverage level/tier. For example: Coverage Level - $xxx per month

Why This Matters column:

c. The insurer must always insert the following language: "The **premium** is the amount paid for health insurance."

2. *What Is The Overall Deductible?:*

Answers column:

a. If there is no calendar year or policy period deductible, answer "$0".

b. If there is a calendar year or policy period deductible, answer with the dollar amount and indicate whether it is based on a calendar year, or policy period. For example: "$5,000 for calendar year" or "$5,000 for policy period".

c. If there is a calendar year or policy period deductible, underneath the dollar amount insurers must include language specifying major categories of covered services that are NOT subject to this deductible. For example, "Does not apply to preventive care and generic drugs".

d. If there is a calendar year or policy period deductible, underneath the dollar amount insurers must include language listing major exceptions, such as out-of-network coinsurance, deductibles for specific services and copayments, which do not count toward the deductible. For example, "Out-of-network coinsurance and copayments don't count toward the deductible."

e. Show the answer for the type of policy only. For example, if this is an individual policy, show answers only for individual. If a family policy and there is a single deductible amount for the family, show answers only for family.

f. If portraying a family policy for which there is a separate deductible amount for each individual and the family, show the individual deductible on the first line, and the family deductible on the second line. For example, the first line may show "Individual $2,000" and the second line may show "Family $3,000".

Why This Matters column:

g. If there is no calendar year or policy period deductible, show the following language: "See the chart starting on page 2 for your other costs for services this plan covers".

h. If there is a calendar year or policy period deductible, show the following language: "You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**."

3. *Are There Other Deductibles for Specific Services?:*

Answers column:

a. If the calendar year or policy period deductible is the only deductible, answer with the phrase "No, there are no other deductibles." Do not answer with just one word.

b. If there are other deductibles, answer "Yes", then list the names and deductible amounts of the three most significant deductibles other than the annual deductible.

Significance of deductibles are determined by the insurer based on two factors: probability of use and financial impact on the employee. Examples of other deductibles include deductibles for Prescription Drug, Hospital, and Mental Health). For example: "Yes, $2,000 for prescription drug expenses and $2,000 for occupational therapy services".

c. If the plan has more than three other deductibles and not all deductibles are shown, the following statement must appear at the end of the list: "There are other deductibles."

d. If the plan has less than three other deductibles, the following statement must appear at the end of the list: "There are no other deductibles."

e. Show the answer for the type of policy only. For example, if this is an individual policy, show answers only for individual. If this is a family policy and there is a single deductible amount for the family, show answers only for family.

f. If portraying a family policy for which there is a separate deductible amount for each individual and the family, show both the individual and family deductible. For example: "Prescription drugs -- Individual $200, Family $500"

Why This Matters column:

g. If there are no other deductibles, the insurer must show the following language: "Because you don't have to meet **deductibles** for specific services, this plan starts to cover costs sooner."

h. If there are other deductibles, the insurer must show the following language: "You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services."

4. ***Is There An Out-of-Pocket Limit On My Expenses?***

Answers column

a. If there are no out-of-pocket limits, respond "No. There's no out-of-pocket limit on your expenses" on the first line. Do not respond with a one-word answer.

b. If there is an out-of-pocket limit, respond "Yes", along with a specific dollar amount that applies in each plan year, and to each charge with a separate out-of-pocket limit on the first line. For example: "Yes. $5,000".

c. If there are other types of annual limits, such as annual or plan year limits on visits, services or drugs, then the insurer must show the following language on the second line: "Other limits apply – see the chart that starts on page 2."

d. If an individual policy, show answers only for individual. If a family policy and there is a single out-of-pocket limit for the family, show answers only for family.

e. If a family policy, and there is a single out-of-pocket limit for each individual and a separate out-of-pocket limit for the family, show the individual out-of-pocket limit on the first line, and the family out-of-pocket limit on the second line. For example, the first line may show "Individual $1,000" and the second line may show "Family $3,000".

Why This Matters column:

f. If there is an out-of-pocket limit, the insurer must show the following language: "The **out-of-pocket** limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses."

g. If there is no out-of-pocket limit, the insurer must show the following language: "There's no limit on how much you could pay during a policy period for your share of the cost of covered services."

5. ***What Is Not Included In The Out-of-Pocket Limit?***

Answers column

a. If there is no out-of-pocket limit, indicate "This question doesn't apply to this plan."

b. If there is an out-of-pocket limit, the insurer must list any major exceptions. This list must always include: premium, balance-billed charges, and health care this plan doesn't cover. Depending on the policy, the list could also include: copayments, out of network coinsurance, deductibles, and penalties for failure to obtain pre-authorization for services. The insurer must state that these items do not count toward the limit. For example: "Copayments, premium, balance-billed charges, and health care this plan doesn't cover."

Why This Matters column:

c. If there is an out-of-pocket limit, the insurer must show the following language: "Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. So, a longer list of expenses means you have less coverage."

d. If there is no out-of-pocket limit, the insurer must show "Not applicable because there's no **out-of-pocket limit** on your expense."

6. ***Is There An Overall Annual Limit On What The Insurer Pays?***

Answers column

a. The insurer should respond "Yes" or "No" based on whether the policy has an overall annual limit.

b. If the answer is "Yes", the insurer should include a brief description and dollar amount of the overall annual limit. For example: "Yes. This policy has an overall annual limit of $750,000".

c. If the answer is "No", the insurer should state, "No. This policy has no overall annual limit on the amount it will pay each year."

Why This Matters column:

d. If there is an overall annual limit, the insurer must show the following language: "This plan will pay for covered services only up to this limit during each policy period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits such as limits on the number of office visits."

e. If there is no overall annual limit, the insurer must show the following language: "The chart starting on page 2 describes any limits on what the insurer will pay for *specific* covered services, such as office visits."

7. ***Does This Plan Use A Network of Providers?:***

Answers column

a. If this plan does not use a network, the insurer must respond, "No. This plan doesn't use a network". Do not use a one-word response.

b. If the plan does use a network, the insurer must briefly explain its network policy. For example "Yes, this plan uses preferred providers. You may use health care providers that aren't preferred providers, but you may pay more."
c. Insurers have the ability to use plan specific language when distinguishing between preferred provider and non-preferred provider or in-network and out-of-network out-of-pocket limits, etc.
d. Include information on where to find a list of preferred providers or in-network providers, etc. For example "For a list of preferred providers, see www.insurancecompany.com or call 1-888-123-4567."
e. ER and other exceptions to non-preferred provider requirements should add that information to answer field.
f. Plans should highlight that some out-of-network specialists are often used by network providers (e.g., anesthesiologists).

Why This Matters column:

g. If this plan uses a network, the insurer must show the following language: "If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the terms **in-network**, **preferred**, or **participating** to refer to providers in their network."
h. If this plan does not use a network, the insurer must show the following language: "The providers you choose won't affect your costs."

8. ***Do I Need A Referral To See A Specialist?:***

Answers column:

a. Insurers have the ability to use plan specific language when distinguishing between preferred provider and non-preferred specialists or in-network and out-of-network out-of-pocket limits, etc.
b. Insurers should specify whether a written or verbal approval is required to see a specialist.
c. Insurers should specify whether specialist approval is different for different plan benefits.

Why This Matters column:

d. If there is a referral required, the insurer must show the following language: "This plan will pay some or all of the costs to see a specialist but only if you have the plan's permission before you see the **specialist** for covered services."
e. If there is no referral required, the insurer must show the following language: "You can see the **specialist** you choose without permission from this plan".

9. ***Are there services this plan doesn't cover?:***

Answers column:

a. If there are any items in the *Services Your Plan Does Not Cover* box in the on page 3 or 4, the insurer should answer "Yes". See the instructions for the *Excluded Services and Other Covered Services* section for more related information.

Why This Matters column:

b. If there are no excluded services shown in the *Services Your Plan Does Not Cover* box on page 3 or 4, then the insurer must show the language: "This plan also

covers many other common health care services listed on page [3 or 4]." The insurer should note the correct page (3 or 4) depending on where the *Services Your Plan Does Not Cover* box appears on the form.

c. If there are excluded services shown in the *Services Your Plan Does Not Cover* box on page 3 or 4, then the insurer must show the language: "Some of the services this plan doesn't cover are listed on page [3 or 4]." The insurer should insert the correct page (3 or 4) depending on where the *Services Your Plan Does Not Cover* box appears on the form.

Covered Services, Cost Sharing, Limitations and Exceptions

Information Box:

- The information box at the top of Page 2 should be replicated with the same text, formatting, graphic, bolded words, and bullet points. Only the fourth bullet may change.
- The fourth bullet will change depending on the plan:
  - For most plans that use a network, the insurer should fill in the blank on the 4th bullet, using the terminology that the insurer uses for "in-network" or "preferred provider". This should be the same term as used in the heading of the far-left sub-column under the *Your Cost* column.
  - For plans that have the same cost-sharing percentage for in-network services as out-of-network services, the insurer should delete the 4th bullet and replace it with: "Your costs for [in-network] providers will be lower than [out-of-network] providers." Insert the term used for in-network and out-of-network shown on the sub-column headers under the *Your Cost* column.
  - For non-networked plans, the insurer should delete the 4th bullet and replace it with: "Your costs are the same no matter which provider you see."
- If any of the explanations in this box are inaccurate for the plan, then the insurer should use the chart below (in either the *Your Cost* column or the *Limitations and Exceptions* column) to show that information. For instance, if cost-sharing is not subject to the deductible (and therefore the second bullet is not accurate for this plan), then the insurer should indicate in the *Your Cost* column next to each cost-sharing charge that the charge is "not subject to the deductible".

Chart Starting on Page 2 :

1. **Location of Chart:** This chart must always begin on Page 2, and the rows shown on Pages 2 and 3 must always appear in the same order. However, the rows shown on Page 2 may extend to Page 3 if space requires, and the rows shown on Page 3 may extend to the beginning of Page 4 if space requires. The heading of the chart must appear on all pages used.

2. ***Your Cost* columns:**
   a. Insurers may vary the number of sub-columns depending upon the type of policy and the number of preferred provider networks. Most policies that use a network should use two columns, although some policies with more than one level of in-

network provider may use three columns. HMOs should use two columns. Non-networked plans may use one column.

b. Insurers should insert the terminology used in the policy to title the sub-columns. For example, the columns may be called "In-Network" and "Out-of-Network", or "Preferred Provider" and "Non-Preferred Provider" based on the terms used in the policy. Insurers should be aware that consumer testing has demonstrated that consumers more readily understand the terms "In-Network" and "Out-of-Network". The sub-headings should be deleted for non-networked plans with only one column.

c. The columns should appear from left to right, from most in-network to most out-of-network. For example, if a 3-column format is used, the sub-columns might be labeled (from left to right) "In-Network Preferred Provider," "In-Network Provider," and then "Out-of-Network Provider."

d. For HMOs providing no out-of-network benefits, the insurer should insert "Not covered" in all applicable boxes under the far-right sub-heading under the *Your Cost* column (which, for policies providing out-of-network benefits, would usually be out-of-network provider or non-preferred provider column.

e. Insurers must complete the responses under these sub-columns based on how the health insurance coverage covers the specific services listed in the chart.

1) Fill in the costs column(s) with the co-insurance percentage, the co-payment amount, "No charge" if the employee pays nothing, or "Not covered" if the service is not covered by the plan. When referring to coinsurance, include a percentage valuation. For example: 20% coinsurance. When referring to co-payments, include a per occurrence cost. For example: $20/visit or $15/prescription.

2) When responding with a list of items, use words such as "and", "or", or "plus" rather than using a semi-colon. For example: "Yes, $5,000 deductible for prescription drugs and $2,000 for occupational therapy" rather than "Yes, $5,000 for prescription drugs; $2,000 for occupational therapy".

3. *Limitations and Exceptions* column:

a. In this column, list the significant limitations and exceptions for each row. Significance of limitations and exceptions is determined by the insurer based on two factors: probability of use and financial impact on the employee. Examples include, but are not limited to, limits on the number of visits, limits on specific dollar amount paid by the insurer, prior authorization requirements, unusual exceptions to cost sharing, lack of applicability of a deductible, or a separate deductible.

b. The limitation and exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."

c. If the policy requires the employee to pay 100% of a service in-network, then that should be considered an "excluded service" and should appear in the *Limitations and Exceptions* column and also appear in the *Services Your Plan Does Not Cover*

box on Page 3 or 4. For example, policies that exclude services in-network such as pregnancy, habilitation services, prescription drugs, or mental health services, must show these exclusions in both the *Limitations and Exceptions* column and the *Services Your Policy Does Not Cover* box.

d. If there are pre-authorization requirements, the insurer must show the requirement including specific information about the penalty for non-compliance.

e. If there are no items that need to appear in the limitations and exceptions box for a row, then the insurer should show "----none---".

f. For each section of the chart (for each *Common Medical Event*), the insurer has the discretion to merge the boxes in the *Limitations and Exceptions* column and display one response across multiple rows if such a merger would lessen the need to replicate comments and would save space.

4. Specific Instructions for *Common Medical Events:*

a. *If you visit a health care provider's office or clinic:*

1) If the policy covers other practitioners care (which includes chiropractic care and/or acupuncture), in the "Other practitioner office visit" row, the insurer will provide the cost-sharing for the other practitioners care in the *Your Cost* columns. For example, under in-network sub-column, the insurer may respond "20% coinsurance for chiropractor and 10% coinsurance for acupuncture".

2) If the policy does not cover other practitioners care, the insurer will show "Not Covered" in the Your Cost columns for *Other Practitioner Office visit*.

b. *If you need drugs to treat your illness or condition:*

1) Under the *Common Medical Events* column, provide a link to the website location where the employee can find more information about prescription drug coverage for this policy.

2) Under the *Services You May Need* column, the insurer should list and complete the categories of prescription drug coverage in the policy (for example, the insurer might fill out 4 rows with the terms, "Generic drugs", "Preferred brand drugs", "Non-preferred brand drugs", and "Specialty drugs". It is recommended that insurers avoid the term "tiers" and instead use "categories" as it is more easily understood by consumers.

3) Under the *Your Cost* column, insurers should include the cost-sharing for both retail and mail-order.

c. *If you have outpatient surgery:*

1) If there are significant expenses associated with a typical outpatient surgery that have higher cost-sharing than the facility fee or physician/surgeon fee, or are not covered, then they must be shown under the *Limitations and Exceptions* column. Significance of such expenses are determined by the insurer based on two factors: probability of use and financial impact on the employee. For example, an insurer might show

that the cost-sharing for the physician/surgeon fee row is "20% coinsurance", but the *Limitations and Exceptions* might show "Radiology 50% coinsurance".

d. If you have a hospital stay:

1) If there are significant expenses associated with a typical hospital stay that has higher cost-sharing than the facility fee or physician/surgeon fee, or are not covered, then that must be shown in under the *Limitations and Exceptions* column. Significance of such expenses are determined by the insurer based on two factors: probability of use and financial impact on the employee. For example, an insurer might show that the cost-sharing for the facility fee row is "20% coinsurance", but the *Limitations and Exceptions* might show "anesthesia 50% coinsurance".

Disclosures:

The *Excluded Services and Other Covered Services*, *Your Rights to Continue Coverage*, *Your Grievance and Appeals Rights* and *Coverage Examples* sections must always appear in the order shown. The *Excluded Services and Other Covered Benefits* section may appear on Page 3 or Page 4 depending on the length of the chart starting on page 2, but it will always follow immediately after the chart starting on page 2.

Excluded Services and Other Covered Services:

1. Each insurer must place all services listed below in either the "*Services Your Plan Does Not Cover*" box or the "*Other Covered Services*" box according to the policy provisions. The required list of services includes: Acupuncture, Bariatric Surgery, Non-emergency care when travelling outside the U.S., Chiropractic Care, Cosmetic Surgery, Dental care (adult), Hearing aids, Infertility treatment, Long-term care, Private-duty nursing, Routine eye care (adult), Routine foot care, and Weight loss programs.

2. The insurer may not add any other benefits to the *Other Covered Services* box other than the ones listed in (1) above.

3. Services that appear in the *Limitations and Exceptions* column in the chart starting on page 2 because the policy requires the employee to pay 100% of the service in-network, should also appear in the *Services Your Plan Does Not Cover* box. For example, policies that exclude services in-network such as pregnancy, habilitation services, prescription drugs, or mental health services, must show these exclusions in both the *Limitations and Exceptions* column (in the *c*hart starting on page 2 chart) and in this *Services Your Plan Does Not Cover* box.

4. List placement must be in alphabetical order for each box. The lists must use bullets next to each item.

5. For example, if an insurer excludes all of the services on the list above (#1) except Chiropractic services, and also showed exclusion of Habilitation Services on Page 2 and exclusion of Dental care (child) on page 3, the Other Benefits Covered box would show "Chiropractic Care" and the *Services Your Plan Does Not Cover* box would show "Acupuncture, Non-emergency care when travelling outside the U.S., Cosmetic surgery, Dental care (child), Habilitation Services, Infertility treatment, Long-term care, Private-duty nursing, Routine eye care (adult), Routine foot care, Routine hearing tests, Weight loss programs."

6. If the insurer provides limited coverage for one of the services listed in (1) above, the limitation must be stated in the *Services Your Plan Does Not Cover* box or the *Other Benefits Covered* box. For example if an insurer provides acupuncture in limited circumstances, the statement in the *Services Your Plan Does Not Cover* box would show: Acupuncture unless it is prescribed by a physician for rehabilitation purposes, Non-emergency care when travelling outside the U.S., Cosmetic surgery, Dental care (adult), Infertility treatment, Long-term care, Private-duty nursing, Routine eye care (adult), Routine foot care, Routine hearing tests, Weight loss programs."

Your Rights to Continue Coverage:

This section must appear. Insurers must include the following items for all policies:

- "you or your employer commit fraud or intentional misrepresentations of material fact",
- "the insurer stops offering this policy or services in the state"
- "you move outside the coverage area"

Insurers must also include the following for group plans:

- "your employer/sponsor changes insurance carrier"
- "your employer cancels or non-renews your coverage"
- "your employment/sponsorship terminates and you are not eligible to continue coverage under COBRA or state law"

Your Grievance and Appeals Rights:

This section must appear. Depending on where plans are sold, identify the proper state health insurance customer assistance program and include their website and phone number.

Coverage Examples:

a. HHS will provide all insurers with standardized data to be inserted in the "Sample care costs" section for each coverage example. HHS will also provide underlying detail that will allow carriers to calculate "You Pay" amounts, payments including: Date of Service, CPT code, Provider Type, Category, descriptive Notes identifying the specific service provided, and Allowed Amount.

b. The "Amount owed to providers," also known as the Allowed Amount, will always equal the Total of the "Sample care costs." Each insurer must calculate cost sharing, using the detailed data provided by HHS, and populate the "You Pay" fields. Dollar values are to be rounded off to the nearest hundred dollars (for Sample care costs that are equal to or greater than $100) or to the nearest ten dollars (for Sample care costs that are less than

$100), in order to reinforce to consumers that numbers in the examples are estimates and do not reflect their actual medical costs. For example, if the coinsurance amount is estimated at $57, the insurer would list $60 in the appropriate "You Pay" section of the Coverage Example.

c. Services on the template provided by HHS are listed individually for classification and pricing purposes to facilitate the population of the "You Pay" section. HHS specifies the Category used to roll up detail costs into the "Sample care costs" categories section. Some plans may classify that service under another category and should reflect that difference accordingly. The insurer should apply their cost sharing and benefit features for each policy in order to complete the "You pay" section, but must leave the "Sample care costs" section as is. Examples of categories that might differ between the You Pay and Sample Care Costs sections could include, but are not limited to:
    - Payment of services based on the location where they are provided (inpatient, outpatient, office, etc.)
    - Payment of items as prescription drugs vs. medical equipment

d. Each insurer must calculate and populate the "You pay" total and sub-totals based upon the cost sharing and benefit features of the plan for which the document is being created. These calculations should be made using the order in which the services were provided (Date of Service).

    1. **Deductible** – includes everything the member pays up to the deductible amount. Any co-pays that accumulate toward the deductible are accounted for in this cost sharing category, rather than under co-pays

    2. **Co-pays** – those co-pays that don't apply to the deductible

    3. **Limits or exclusions** – anything member pays for non-covered services or services that exceed plan limits.

    4. **Co-insurance** – anything member pays above the deductible that's not a co-pay or non-covered service. This should be the same figure as the Total less the Deductible, Co-Pays and Limits.

e. Each insurer must calculate and populate the "Plan pays" amount by subtracting the "You pay" total from the "Amount owed to providers" total.

f. If all of the costs associated with the "having a baby" example are excluded under the plan, then the phrase "(maternity is not covered, so you pay 100%)" is added after the "You pay" amount. Otherwise no narrative should appear after the "You pay" amount.

g. Insurers must use the "Questions and answers about Coverage Examples" as they appear and not alter the text, font, graphic, shading or colors [Should insurers be allowed to print in black and white?]. This should be placed immediately following the Coverage Examples.

h. If the insurer provides coverage only for medical services (e.g., pharmacy or mental health benefits are carved out and administered by another insurer), the insurer should complete the Coverage Example for only those benefits that it covers, consistent with the features outlined on pages 1 to 4 of the Summary of Coverage. These non-covered costs for excluded services would show up under the "limits and exclusions" section of the "You Pay" table. [NOTE: Should we require inclusion of a disclaimer on the Coverage Example (and on the Summary of Coverage) that notes that certain benefits may be administered by a separate insurer? Should we also amend the instructions for the Summary of Coverage to address this issue in terms of how the benefits are described?]

Need Assistance?

Insurers should contact _____ at _____ to obtain assistance in completing these documents.

What Your Plan Covers and What it Costs

Draft Instruction Guide for Individually Purchased or Non-Group Policies

Edition Date: July 2011

Purpose of the form: Beginning in March 2012, the Patient Protection and Affordable Care Act (PPACA) requires all health insurance issuers offering individual health insurance coverage to provide enrollees and potential enrollees an accurate summary of benefits and coverage explanation. This form does not apply to excepted benefits as defined by the Public Health Services Act (PHSA). Federal law requires this document so consumers will find it easier to compare policies and understand their coverage.

Requirements to provide the form: As set forth below, this form must be provided to an applicant, to the policyholder or to the certificate holder at the time of issuance of the policy or delivery of the certificate and to the policyholder or certificate holder at renewal, as applicable.

While it is the insurer's, or a representative of the insurer's, responsibility to accurately fill out and deliver the form, these instructions acknowledge that consumers receive information about their health insurance through three primary channels of communication: 1) insurance companies, 2) agents, and 3) solicitations made via telemarketers and the internet. The following are the permitted methods of delivery:

a. When an insurer, or a representative of an insurer, meets in person with the potential applicant, the insurer or a representative of the insurer may hand-deliver the completed form to the individual. Alternatively, the insurer, or representative of the insurer, may offer the individual the following options, and shall provide the form to be delivered in the manner selected by the individual:
   1) A printed copy deposited in the United States mail, postage pre-paid, within seven (7) days of the request;
   2) An electronic copy delivered to an e-mail address provided by the individual;
   3) An electronic copy delivered via a link on the Internet;
   4) A copy delivered by any other means acceptable to both the insurer and the individual.

b. For an applicant who conducts the insurance application electronically, the insurer, or a representative of the insurer, must make the form available on the electronic site and the insurer must require the applicant to acknowledge receipt of the form as a necessary step to completing the initial application process.

c. For an insurance application that is completed over the phone or through the mail, the insurer, or a representative of the insurer, shall offer a printed copy of the completed form

within seven (7) days to the address provided by the applicant. Alternatively, the insurer, or representative of the insurer, may offer the individual the following options, and shall provide the form to be delivered in the manner selected by the individual:

1) An electronic copy delivered to an e-mail address provided by the individual;
2) An electronic copy delivered via a link on the Internet;
3) A copy delivered by any other means acceptable to both the insurer and the individual.

d. When an insurer issues a policy or delivers a certificate the form shall be included with the policy or certificate and provided in the manner selected by the policy holder or certificate holder.

e. When the policy or certificate is renewed, the insurer shall provide the form in the same manner in which the policy or certificate were provided along with the renewal documents.

An oral description of the form is not sufficient. An insurer, or a representative of the insurer, may not provide the form solely by orally explaining the form and its contents either in person or over the telephone.

If two or more applicants jointly request an insurance product or service from an insurer, the insurer may satisfy the requirement to provide this form by providing one form to those applicants jointly.

Unless otherwise required by law, this form is a freestanding document and may not be incorporated into any other document that an insurer, or an insurer's representative, provides to an applicant, policy holder or certificate holder.

General Instructions: Read all instructions carefully before completing the form.

- This form must be filled out accurately and by the insurer in good faith.
- Form language and formatting must be precisely reproduced, unless instructions allow or instruct otherwise. Unless otherwise instructed, the insurer must use 12-point (as required by federal law) Times New Roman font, and replicate all symbols, formatting, bolding, colors, and shading exactly. Attached is an example of a blank form.
- Insurers must customize all identifiable company information throughout the document, including websites and telephone numbers.
- If there is a different amount for in-network and out-of-network expenses (such as annual deductible, additional deductibles, or out-of-pocket limits), list both amounts and indicate as such, using the terms to describe provider networks used by the insurer. For example, if the policy uses the terms "preferred provider" and "non-preferred provider" and the annual deductible is $2,000 for a preferred provider and $5,000 for a non-preferred provider, then the Answer column should show "$2000 preferred provider, $5,000 non-preferred provider".
- The items shown on Page 1 must always appear on Page 1, and the rows of the chart must always appear in the same order. The chart starting on page 2 shown in the example must always begin on Page 2, and the rows shown on this chart must always appear in the

same order. However, the chart rows shown on Page 2 may extend to Page 3 if space requires, and the chart rows on Page 3 may extend to the beginning of Page 4 if space requires. The *Excluded Services and Other Covered Services* section may appear on Page 3 or Page 4, but must always immediately follow the chart starting on page 2. The *Excluded Services and Other Covered Services* section must be followed by the *Your Rights to Continue Coverage* section, the *Your Grievance and Appeals Rights* section, and the *Coverage Examples* section, in that order.

- Footer: The footer must appear at the bottom left of every page. The insurer must insert the appropriate telephone number and website information.
- For all form sections to be filled out by the insurer (particularly in the *Answers* column on page 1, and the *Your Cost* and *Limitations and Exceptions* columns in the chart that starts on page 2), the insurer should use plain language and present the information in a culturally and linguistically appropriate manner and utilize terminology understandable by the average individual.

Filling out the form:

Top Left Header (Page 1):

On the top left hand corner of the first page, the insurer must show the following information:

- **First line:** Show the plan name and insurance company name in 16 point font and bold. Example: "**Maximum Health Plan: Alpha Insurance Group**".
    - Insurers have the option to use their logo instead of the typing in the company name if the logo includes the name of the entity issuing the coverage.
    - The insurer must use the commonly known company name.

Top Right Header (Page 1):

On the top right hand corner of the first page, the insurer must show the following information:

- **First line:** After *Policy Period*, the insurer must show the beginning and end dates for the applicable policy period in the following format: "MM/DD/YYYY – MM/DD/YYYY". For example: "Policy Period: 09/15/2010 - 09/14/2011".
- **Second line**:
    - After the words "Coverage For", indicate who the policy is for (such as Individual, Individual + Spouse, Family). The insurer will use the terms used by the policy, but should ensure that the term used will make it easy for the consumer to compare similar types of plans.
    - After the words "Plan Type", indicate the type of insurance plan, such as HMO, PPO, POS, Indemnity, or High-deductible.

Disclaimer (Page 1):

The disclaimer should be replicated and the insurer may not vary the font size, graphic or formatting. The insurer should insert the plan's website and telephone number.

Important Questions/Answers/ Why This Matters Chart

General Instructions for the *Important Questions* chart:

- This chart must always appear on Page 1, and the rows must always appear in the same order. Insurers must complete the *Answers* column for each question on this chart, using the instructions below.
- Insurers must show the appropriate language in the *Why This Matters* box as instructed in the instructions below. Insurers must replicate the language given for the *Why This Matters* box exactly, and may not alter the language.
- When responding with a list of items, use words such as "and", "or", or "plus" rather than using a semi-colon. For example: "Yes, $5,000 deductible for prescription drugs and $2,000 for occupational therapy" rather than "Yes, $5,000 for prescription drugs; $2,000 for occupational therapy".

1. *What Is The Premium?*:

Answers column:

a. Answer with the dollar amount (rounded to the closest whole dollar) and time period (such as monthly). Example: "$[xxx] [monthly]".

b. Premium amounts may be provided in good faith by the insurer or agent.

c. If a consumer is shopping for plans and has yet to fill out a health insurance application or has not yet been medically underwritten, insurers may, consistent with state law, use a base premium based on five factors: the number of people to be covered by the policy (i.e. individual or family), age, gender, smoking status, and location (zip code).

Why This Matters column:

d. The insurer must always insert the following language: "The **premium** is the amount paid for health insurance."

e. If the consumer is shopping for plans and has been provided a base premium as described in (c) above, the insurer must also include the statement: "This is only an estimate based on information you've provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied". This sentence should appear immediately after the sentence described in (d) above.

2. *What Is The Overall Deductible?*:

Answers column:

a. If there is no calendar year or policy period deductible, answer "$0".

b. If there is a calendar year or policy period deductible, answer with the dollar amount and indicate whether it is based on a calendar year, or policy period. For example: "$5,000 for calendar year" or "$5,000 for policy period".

c. If there is a calendar year or policy period deductible, underneath the dollar amount insurers must include language specifying major categories of covered services that are NOT subject to this deductible. For example, "Does not apply to preventive care and generic drugs".

d. If there is a calendar year or policy period deductible, underneath the dollar amount insurers must include language listing major exceptions, such as out-of-

network coinsurance, deductibles for specific services and copayments, which do not count toward the deductible. For example, "Out-of-network coinsurance and copayments don't count toward the deductible."

e. Show the answer for the type of policy only. For example, if this is an individual policy, show answers only for individual. If a family policy and there is a single deductible amount for the family, show answers only for family.

f. If portraying a family policy for which there is a separate deductible amount for each individual and the family, show the individual deductible on the first line, and the family deductible on the second line. For example, the first line may show "Individual $2,000" and the second line may show "Family $3,000".

Why This Matters column:

g. If there is no calendar year or policy period deductible, show the following language: "See the chart starting on page 2 for your other costs for services this plan covers."

h. If there is a calendar year or policy period deductible, show the following language: "You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**."

3. *Are There Other Deductibles for Specific Services?*:

Answers column:

a. If the calendar year or policy period deductible is the only deductible, answer with the phrase "No, there are no other deductibles." Do not answer with just one word.

b. If there are other deductibles, answer "Yes", then list the names and deductible amounts of the three most significant deductibles other than the annual deductible. Significance of deductibles are determined by the insurer based on two factors: probability of use and financial impact on the consumer. Examples of other deductibles include deductibles for Prescription Drug, Hospital, and Mental Health). For example: "Yes, $2,000 for prescription drug expenses and $2,000 for occupational therapy services".

c. If the plan has more than three other deductibles and not all deductibles are shown, the following statement must appear at the end of the list: "There are other deductibles."

d. If the plan has less than three other deductibles, the following statement must appear at the end of the list: "There are no other deductibles."

e. Show the answer for the type of policy only. For example, if this is an individual policy, show answers only for individual. If this is a family policy and there is a single deductible amount for the family, show answers only for family.

f. If portraying a family policy for which there is a separate deductible amount for each individual and the family, show both the individual and family deductible. For example: "Prescription drugs -- Individual $200, Family $500"

Why This Matters column:

g. If there are no other deductibles, the insurer must show the following language: "Because you don't have to meet **deductibles** for specific services, this plan starts to cover costs sooner."

h. If there are other deductibles, the insurer must show the following language: "You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services."

4. ***Is There An Out-of-Pocket Limit On My Expenses?***

Answers column

a. If there are no out-of-pocket limits, respond "No. There's no out-of-pocket limit on your expenses" on the first line. Do not respond with a one-word answer.

b. If there is an out-of-pocket limit, respond "Yes", along with a specific dollar amount that applies in each plan year, and to each charge with a separate out-of-pocket limit on the first line. For example: "Yes. $5,000".

c. If there are other types of annual limits, such as annual or plan year limits on visits, services or drugs, then the insurer must show the following language on the second line: "Other limits apply – see the chart that starts on Page 2".

d. If an individual policy, show answers only for individual. If a family policy and there is a single out-of-pocket limit for the family, show answers only for family.

e. If portraying a family policy, for which there is a single out-of-pocket limit for each individual and a separate out-of-pocket limit for the family, show the individual out-of-pocket limit on the first line, and the family out-of-pocket limit on the second line. For example, the first line may show "Individual $1,000" and the second line may show "Family $3,000".

Why This Matters column:

f. If there is an out-of-pocket limit, the insurer must show the following language: "The **out-of-pocket** limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses."

g. If there is no out-of-pocket limit, the insurer must show the following language: "There's no limit on how much you could pay during a policy period for your share of the cost of covered services."

5. ***What Is Not Included In The Out-of-Pocket Limit?***

Answers column

a. If there is no out-of-pocket limit, indicate "This question doesn't apply to this plan."

b. If there is an out-of-pocket limit, the insurer must list any major exceptions. This list must always include: premium, balance-billed charges, and health care this plan doesn't cover. Depending on the policy, the list could also include: copayments, out of network coinsurance, deductibles, and penalties for failure to obtain pre-authorization for services. The insurer must state that these items do not count toward the limit. For example: "Copayments, premium, balance-billed charges, and health care this plan doesn't cover."

Why This Matters column:

c. If there is an out-of-pocket limit, the insurer must show the following language: "Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. So, a longer list of expenses means you have less coverage."

d. If there is no out-of-pocket limit, the insurer must show "Not applicable because there's no **out-of-pocket limit** on your expenses".

6. ***Is There An Overall Annual Limit On What The Insurer Pays?***

Answers column

a. The insurer should respond "*Yes*" or "*No*" based on whether the policy has an overall annual limit.

b. If the answer is "Yes", the insurer should include a brief description and dollar amount of the overall annual limit. For example: "Yes. This policy has an overall annual limit of $750,000".

c. If the answer is "No", the insurer should state, "No. This policy has no overall annual limit on the amount it will pay each year."

Why This Matters column:

d. If there is an overall annual limit, the insurer must show the following language: "This plan will pay for covered services only up to this limit during each policy period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits."

e. If there is no overall annual limit, the insurer must show the following language: "The chart starting on page 2 describes any limits on what the insurer will pay for *specific* covered services, such as office visits."

7. ***Does This Plan Use A Network of Providers?:***

Answers column

a. If this plan does not use a network, the insurer must respond, "No. This plan doesn't use a network". Do not use a one-word response.

b. If the plan does use a network, the insurer must briefly explain its network policy. For example "Yes, this plan uses preferred providers. You may use health care providers that aren't preferred providers, but you may pay more."

c. Insurers have the ability to use plan specific language when distinguishing between preferred provider and non-preferred provider or in-network and out-of-network out-of-pocket limits, etc.

d. Include information on where to find a list of preferred providers or in-network providers, etc. For example "For a list of preferred providers, see www.insurancecompany.com or call 1-888-123-4567."

e. ER and other exceptions to non-preferred provider requirements should add that information to answer field.

f. Plans should highlight that some out-of-network specialists are often used by network providers (e.g., anesthesiologists).

Why This Matters column:

g. If this plan uses a network, the insurer must show the following language: "If you use an in-network doctor or other health care provider, this plan will pay some or

all of the costs of covered services. Plans use the terms **in-network**, **preferred**, or **participating** to refer to providers in their network."

h. If this plan does not use a network, the insurer must show the following language: "The providers you choose won't affect your costs."

8. ***Do I Need A Referral To See A Specialist?:***

Answers column:

a. Insurers have the ability to use plan specific language when distinguishing between preferred provider and non-preferred specialists or in-network and out-of-network out-of-pocket limits, etc.

b. Insurers should specify whether a written or verbal approval is required to see a specialist.

c. Insurers should specify whether specialist approval is different for different plan benefits.

Why This Matters column:

d. If there is a referral required, the insurer must show the following language: "This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the specialist."

e. If there is no referral required, the insurer must show the following language: "You can see the **specialist** you choose without permission from this plan".

9. ***Are There Services This Plan Doesn't Cover?:***

Answers column:

a. If there are any items in the *Services Your Plan Does Not Cover* box on page 3 or 4, the insurer should answer "Yes". See the instructions for the *Excluded Services and Other Covered Services* section for more related information.

Why This Matters column:

b. If there are no excluded services shown in the *Services Your Plan Does Not Cover* box on page 3 or 4, then the insurer must show the language: "This plan also covers many common health care services listed on page [3 or 4]." The insurer should note the correct page (3 or 4) depending on where the *Services Your Plan Does Not Cover* box appears on the form.

c. If there are excluded services shown in the *Services Your Plan Does Not Cover* box on page 3 or 4, then the insurer must show the language: "Some of the services this plan doesn't cover are listed on page [3 or 4]." The insurer should insert the correct page (3 or 4) depending on where the *Services Your Plan Does Not Cover* box appears on the form.

Covered Services, Cost Sharing, Limitations and Exceptions

Information Box:

- The information box at the top of Page 2 should be replicated with the same text, formatting, graphic, bolded words, and bullet points. Only the fourth bullet may change.
- The fourth bullet will change depending on the plan:
    - For most plans that use a network, the insurer should fill in the blank on the 4th bullet, using the terminology that the insurer uses for "in-network" or "preferred

provider". This should be the same term as used in the heading of the far-left sub-column under the *Your Cost* column.

- For plans that have the same cost-sharing percentage for in-network services as out-of-network services, the insurer should delete the 4th bullet and replace it with: "Your costs for [in-network] providers will be lower than [out-of-network] providers." Insert the term used for in-network providers and out-of-network providers shown on the sub-column headers under the *Your Costs* column.
- For non-networked plans, the insurer should delete the 4th bullet and replace it with: "Your costs are the same no matter which provider you see."

- If any of the explanations in this box are inaccurate for the plan, then the insurer should use the chart (in either the *Your Cost* column or the *Limitations and Exceptions* column) below to show that information. For instance, if cost-sharing is not subject to the deductible (and therefore the second bullet is not accurate for this plan), then the insurer should indicate in the *Your Cost* column next to each cost-sharing charge that the charge is "not subject to the deductible".

Chart starting on page 2:

1. Location of Chart: This chart must always begin on Page 2, and the rows shown on Pages 2 and 3 must always appear in the same order. However, the rows shown on Page 2 may extend to Page 3 if space requires, and the rows shown on Page 3 may extend to the beginning of Page 4 if space requires. The heading of the chart must appear on all pages used.

2. *Your Cost* columns:

a. Insurers may vary the number of sub-columns depending upon the type of policy and the number of preferred provider networks. Most policies that use a network should use two columns, although some policies with more than one level of in-network provider may use three columns. HMOs should use two columns. Non-networked plans may use one column.

b. Insurers should insert the terminology used in the policy to title the sub-columns. For example, the columns may be called "In-Network" and "Out-of-Network", or "Preferred Provider" and "Non-Preferred Provider" based on the terms used in the policy. Insurers should be aware that consumer testing has demonstrated that consumers more readily understand the terms "In-Network" and "Out-of-Network". The sub-headings should be deleted for non-networked plans with only one column.

c. The columns should appear from left to right, from most in-network to most out-of-network. For example, if a 3-column format is used, the sub-columns might be labeled (from left to right) "In-Network Preferred Provider," "In-Network Provider", and then "Out-of-Network Provider."

d. For HMOs providing no out-of-network benefits, the insurer should insert "Not covered" in all applicable boxes under the far-right sub-heading under the Your Cost column (which, for policies providing out-of-network benefits, would usually be out-of-network provider or non-preferred provider column.

e. Insurers must complete the responses under these sub-columns based on how the health insurance coverage covers the specific services listed in the chart.
   1) Fill in the costs column(s) with the co-insurance percentage, the co-payment amount, "No charge" if the consumer pays nothing, or "Not covered" if the service is not covered by the plan. When referring to coinsurance, include a percentage valuation. For example: 20% coinsurance. When referring to co-payments, include a per occurrence cost. For example: $20/visit or $15/prescription.
   2) When responding with a list of items, use words such as "and", "or", or "plus" rather than using a semi-colon. For example: "Yes, $5,000 deductible for prescription drugs and $2,000 for occupational therapy" rather than "Yes, $5,000 for prescription drugs; $2,000 for occupational therapy".

3. *Limitations and Exceptions* Column:

a. In this column, list the significant limitations and exceptions for each row. Significance of limitations and exceptions is determined by the insurer based on two factors: probability of use and financial impact on the consumer. Examples include, but are not limited to, limits on the number of visits, limits on specific dollar amount paid by the insurer, prior authorization requirements, unusual exceptions to cost sharing, lack of applicability of a deductible, or a separate deductible.

b. The limitation and exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."

c. If the policy requires the consumer to pay 100% of a service in-network, then that should be considered an "excluded service" and should appear in the *Limitations and Exceptions* column and also appear in the *Services Your Plan Does Not Cover* box on Page 3 or 4. For example, policies that exclude services in-network such as pregnancy, habilitation services, prescription drugs, or mental health services, must show these exclusions in both the *Limitations and Exceptions* column and the *Services Your Plan Does Not Cover* box.

d. If there are pre-authorization requirements, the insurer must show the requirement including specific information about the penalty for non-compliance.

e. If there are no items that need to appear in the limitations and exceptions box for a row, then the insurer should show "----none---".

f. For each section of the chart (for each *Common Medical Event*), the insurer has the discretion to merge the boxes in the *Limitations and Exceptions* column and display one response across multiple rows if such a merger would lessen the need to replicate comments and would save space.

4. Specific Instructions for *Common Medical Events:*

a. *If you visit a health care provider's office or clinic:*

1) If the policy covers other practitioners care (which includes chiropractic care and/or acupuncture), in the "Other practitioner office visit" row, the insurer will provide the cost-sharing for the other practitioners care in the *Your Cost* columns. For example, under the in-network sub-column, the insurer may respond "20% coinsurance for chiropractor and 10% coinsurance for acupuncture".
2) If the policy does not cover other practitioners care, the insurer will show "Not Covered" in the Your Cost columns for *Other Practitioner Office visit*.

b. *If you need drugs to treat your illness or condition:*
1) Under the *Common Medical Events* column, provide a link to the website location where the consumer can find more information about prescription drug coverage for this policy.
2) Under the *Services You May Need* column, the insurer should list and complete the categories of prescription drug coverage in the policy (for example, the insurer might fill out 4 rows with the terms, "Generic drugs", "Preferred brand drugs", "Non-preferred brand drugs", and "Specialty drugs". It is recommended that insurers avoid the term "tiers" and instead use "categories" as it is more easily understood by consumers.
3) Under the *Your cost* column, insurers should include the cost-sharing for both retail and mail-order.

c. *If you have outpatient surgery:*
1) If there are significant expenses associated with a typical outpatient surgery that have higher cost-sharing than the facility fee or physician/surgeon fee, or are not covered, then they must be shown under the *Limitations and Exceptions* column. Significance of such expenses are determined by the insurer based on two factors: probability of use and financial impact on the consumer. For example, an insurer might show that the cost-sharing for the physician/surgeon fee row is "20% coinsurance", but the *Limitations and Exceptions* might show "Radiology 50% coinsurance".

d. *If you have a hospital stay:*
1) If there are significant expenses associated with a typical hospital stay that has higher cost-sharing than the facility fee or physician/surgeon fee, or are not covered, then that must be shown in under the *Limitations and Exceptions* column. Significance of such expenses are determined by the insurer based on two factors: probability of use and financial impact on the consumer. For example, an insurer might show that the cost-sharing for the facility fee row is "20% coinsurance", but the *Limitations and Exceptions* might show "anesthesia 50% coinsurance".

Disclosures:

The *Excluded Services and Other Covered Services, Your Rights to Continue Coverage, Your Grievance and Appeals Rights and Coverage Examples* sections must always appear in the order shown. The *Excluded Services and Other Covered Benefits* section may appear on Page 3 or Page 4 depending on the length of the chart starting on page 2, but it will always follow immediately after the chart starting on page 2.

Excluded Services and Other Covered Services:

1. Each insurer must place all services listed below in either the "*Services Your Plan Does Not Cover*" box or the "*Other Covered Services*" box according to the policy provisions. The required list of services includes: Acupuncture, Bariatric Surgery, Non-emergency care when travelling outside the U.S., Chiropractic Care, Cosmetic Surgery, Dental care (adult), Hearing aids, Infertility treatment, Long-term care, Private-duty nursing, Routine eye care (adult), Routine foot care, and Weight loss programs.

2. The insurer may not add any other benefits to the *Other Covered Services* box other than the ones listed in (1) above.

3. Services that appear in the *Limitations and Exceptions* column in the chart starting on page 2 because the policy requires the consumer to pay 100% of the service in-network, should also appear in the *Services Your Plan Does Not Cover* box. For example, policies that exclude services in-network such as pregnancy, habilitation services, prescription drugs, or mental health services, must show these exclusions in both the *Limitations and Exceptions* column (in the chart starting on page 2) and in this *Services Your Plan Does Not Cover* box.

4. List placement must be in alphabetical order for each box. The lists must use bullets next to each item.

5. For example, if an insurer excludes all of the services on the list above (#1) except Chiropractic services, and also showed exclusion of Habilitation Services on Page 2 and exclusion of Dental care (child) on page 3, the Other Benefits Covered box would show "Chiropractic Care" and the *Services Your Plan Does Not Cover* box would show "Acupuncture, Non-emergency care when travelling outside the U.S., Cosmetic surgery, Dental care (child), Habilitation Services, Infertility treatment, Long-term care, Private-duty nursing, Routine eye care (adult), Routine foot care, Routine hearing tests, Weight loss programs."

6. If the insurer provides limited coverage for one of the services listed in (1) above, the limitation must be stated in the *Services Your Plan Does Not Cover* box or the Other Benefits Covered box. For example if an insurer provides acupuncture in limited circumstances, the statement in the *Services Your Plan Does Not Cover* box would show: Acupuncture unless it is prescribed by a physician for rehabilitation purposes, Non-emergency care when travelling outside the U.S., Cosmetic surgery, Dental care (adult),

Infertility treatment, Long-term care, Private-duty nursing, Routine eye care (adult), Routine foot care, Routine hearing tests, Weight loss programs."

***Your Rights to Continue Coverage*:**
This section must appear. Insurers must include the following items:

- "you commit fraud or intentional misrepresentations of material fact",
- "the insurer stops offering this policy or services in the state"
- "you move outside the coverage area"

Insurers must also include the following for association plans:

- "your employer/sponsor changes insurance carrier"

***Your Grievance and Appeals Rights*:**
This section must appear. Depending on where plans are sold, identify the proper state health insurance customer assistance program and include their website and phone number.

***Coverage Examples*:**

a. HHS will provide all insurers with standardized data to be inserted in the "Sample care costs" section for each coverage example. HHS will also provide underlying detail that will allow carriers to calculate "You Pay" amounts, payments including: Date of Service, CPT code, Provider Type, Category, descriptive Notes identifying the specific service provided, and Allowed Amount.

b. The "Amount owed to providers," also known as the Allowed Amount, will always equal the Total of the "Sample care costs." Each insurer must calculate cost sharing, using the detailed data provided by HHS, and populate the "You Pay" fields. Dollar values are to be rounded off to the nearest hundred dollars (for Sample care costs that are equal to or greater than $100) or to the nearest ten dollars (for Sample care costs that are less than $100), in order to reinforce to consumers that numbers in the examples are estimates and do not reflect their actual medical costs. For example, if the coinsurance amount is estimated at $57, the insurer would list $60 in the appropriate "You Pay" section of the Coverage Example.

c. Services on the template provided by HHS are listed individually for classification and pricing purposes to facilitate the population of the "You Pay" section. HHS specifies the Category used to roll up detail costs into the "Sample care cost" categories section. Some plans may classify that service under another category and should reflect that difference accordingly. The insurer should apply their cost sharing and benefit features for each policy in order to complete the "You pay" section, but must leave the "Sample care costs" section as is. Examples of categories that might differ between the You Pay and Sample Care Costs sections could include, but are not limited to:
    - Payment of services based on the location where they are provided (inpatient, outpatient, office, etc.)
    - Payment of items as prescription drugs vs. medical equipment

d. Each insurer must calculate and populate the "You pay" total and sub-totals based upon the cost sharing and benefit features of the plan for which the document is being created. These calculations should be made using the order in which the services were provided (Date of Service).

    1. **Deductible** – includes everything the member pays up to the deductible amount. Any co-pays that accumulate toward the deductible are accounted for in this cost sharing category, rather than under co-pays

    2. **Co-pays** – those co-pays that don't apply to the deductible

    3. **Limits or exclusions** – anything member pays for non-covered services or services that exceed plan limits.

    4. **Co-insurance** – anything member pays above the deductible that's not a co-pay or non-covered service. This should be the same figure as the Total less the Deductible, Co-Pays and Limits.

e. Each insurer must calculate and populate the "Plan pays" amount by subtracting the "You pay" total from the "Amount owed to providers" total.

f. If all of the costs associated with the "having a baby" example are excluded under the plan, then the phrase "(maternity is not covered, so you pay 100%)" is added after the "You pay" amount. Otherwise no narrative should appear after the "You pay" amount.

g. Insurers must use the "Questions and answers about Coverage Examples" as they appear and not alter the text, font, graphic, shading or colors [Should insurers be allowed to print in black and white?]. This should be placed immediately following the Coverage Examples.

h. If the insurer provides coverage only for medical services (e.g., pharmacy or mental health benefits are carved out and administered by another insurer), the insurer should complete the Coverage Example for only those benefits that it covers, consistent with the features outlined on pages 1 to 4 of the Summary of Coverage. These non-covered costs for excluded services would show up under the "limits and exclusions" section of the "You Pay" table. [NOTE: Should we require inclusion of a disclaimer on the Coverage Example (and on the Summary of Coverage) that notes that certain benefits may be administered by a separate insurer? Should we also amend the instructions for the Summary of Coverage to address this issue in terms of how the benefits are described?]

Need Assistance?

Insurers should contact _____ at _____ to obtain assistance in completing these documents.

[Billing Codes: 4830-01-P; 4510-29-P; 4120-01-P]

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

REG-145878-14

RIN 1545-BM53

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210-AB69

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CMS-9938-P

45 CFR Part 147

RIN 0938-AS54

Summary of Benefits and Coverage and Uniform Glossary

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations regarding the summary of benefits and coverage (SBC) and the uniform glossary for group health plans and health insurance coverage in the group and individual markets under the Patient Protection and Affordable Care Act. It proposes changes to the regulations that implement the

disclosure requirements under section 2715 of the Public Health Service Act to help plans and individuals better understand their health coverage, as well as to gain a better understanding of other coverage options for comparison. It proposes changes to documents required for compliance with section 2715 of the Public Health Service Act, including a template for the SBC, instructions, sample language, a guide for coverage example calculations, and the uniform glossary.

DATES: Comment date. Comments are due on or before [**INSERT DATE 60 DAYS AFTER PUBLICATION IN FEDERAL REGISTER**].

ADDRESSES: Written comments on these proposed regulations and documents required for compliance (including the template, instructions, sample language, guide for coverage example calculations, and the uniform glossary) may be submitted to the Department of Labor as specified below. Any comment that is submitted will be shared with the Department of Health and Human Services and the Department of the Treasury, and will also be made available to the public. **WARNING**: Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments are posted on the Internet exactly as received, and can be retrieved by most Internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records. Comments may be submitted anonymously.

Comments, identified by "Summary of Benefits and Coverage," may be submitted by one of the following methods:

- Federal eRulemaking Portal: http://www.regulations.gov. Follow the instructions for submitting comments.

- Mail or Hand Delivery: Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, Room N-5653, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210, Attention: Summary of Benefits and Coverage.

Comments received will be posted without change to http://www.regulations.gov, and available for public inspection at the Public Disclosure Room, N-1513, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Washington, DC 20210, including any personal information provided.

FOR FURTHER INFORMATION CONTACT: Amy Turner or Beth Baum, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 622-6080; Heather Raeburn or Tricia Beckmann, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (301) 492-4224 or (301) 492-4328.

Customer service information: Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the Department of Labor's website (http://www.dol.gov/ebsa). In addition, information from HHS on private health insurance for consumers can be found on CMS's website (www.cms.gov/cciio) and information on health reform can be found at http://www.healthcare.gov.

SUPPLEMENTARY INFORMATION:

I. Background

The Patient Protection and Affordable Care Act, Pub. L. 111-148, was enacted on March 23, 2010; the Health Care and Education Reconciliation Act, Pub. L. 111-152, was

IV. Applicability

After publication of the 2012 final regulations, the Departments received questions about the applicability of the SBC requirements to certain types of group health plans, including expatriate health plans, Medicare Advantage plans, and insurance products that are no longer being offered for purchase (closed blocks of business). The Departments addressed the applicability of the SBC requirements to each of these types of coverage in FAQs issued after publication of the 2012 final regulations. The Departments also received questions regarding the applicability of the SBC requirements to benefits provided under certain account-type arrangements such as health FSAs,[50] HRAs,[51] and health savings accounts (HSAs),[52] as well as benefits provided through an employee assistance program (EAP) and other excepted benefits.

In May 2012, the Departments issued FAQs that discussed the special circumstances and considerations faced by expatriate plans in complying with the SBC requirements.[53] The FAQs provided temporary relief from enforcement. Under recently enacted legislation,[54] expatriate health plans are not subject to the requirement to provide an SBC. The Departments intend to issue guidance implementing this legislation. The temporary relief from enforcement for expatriate plans will remain in place until such guidance is issued.

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[50] See Code section 106(c)(2).
[51] See IRS Notice 2002-45, 2002-2 C.B. 93.
[52] See Code section 223.
[53] *See* Affordable Care Act Implementation FAQs Part IX, question 13, available at http://www.dol.gov/ebsa/faqs/faq-aca9.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.
[54] See Consolidated and Further Continuing Appropriations Act, 2015, Division M, Expatriate Health Coverage Clarification Act of 2014, Section 3(d).

Moreover, in August 2012, the Departments issued FAQs that discussed group health plans providing Medicare Advantage benefits, which are Medicare benefits financed by the Medicare Trust Funds, for which the benefits are set by Congress and regulated by the Centers for Medicare & Medicaid Services. Again, the FAQs provided a temporary nonenforcement policy, because Medicare Advantage benefits are not health insurance coverage and Medicare Advantage organizations are not required to provide an SBC with respect to such benefits. Additionally, there are separately required disclosures required to be provided by Medicare Advantage organizations, to ensure that enrollees in these plans receive the necessary information about their coverage and benefits. These rules propose to exempt from the SBC requirements a group health plan benefit package that provides Medicare Advantage benefits.

The Departments also issued FAQs in May 2012 addressing insurance products that are no longer being offered for purchase ("closed blocks of business").
Some interested stakeholders had requested enforcement relief with respect to such products because the products are no longer offered for purchase and the SBC is intended to be a tool to help group health plans and individuals as they shop for coverage. The Departments had provided temporary relief through an FAQ provided that certain conditions were met: (1) the insurance product is no longer being actively marketed; (2) the health insurance issuer stopped actively marketing the product prior to September 23, 2012, when the requirement to provide an SBC was first applicable to health insurance issuers; and (3) the health insurance issuer has never provided an SBC with respect to

such product.[55] The Departments reiterate that relief here, but note that if an insurance product was actively marketed for business on or after September 23, 2012, and is no longer being actively marketed for business, or if the plan or issuer ever provided an SBC in connection with the product, the plan and issuer must provide the SBC with respect to such coverage, as required by PHS Act section 2715 and the regulations.

As under the 2012 final regulations, an SBC need not be provided for plans, policies, or benefit packages that constitute excepted benefits. Thus, for example, an SBC need not be provided for stand-alone dental or vision plans or health FSAs if they constitute excepted benefits under the Departments' regulations.[56] If benefits under a health FSA do not constitute excepted benefits, the health FSA is a group health plan generally subject to the SBC requirements. For a health FSA that does not meet the criteria for excepted benefits and that is integrated with other major medical coverage, the SBC is prepared for the other major medical coverage, and the effects of the health FSA can be denoted in the appropriate spaces on the SBC, including those for deductibles, copayments, coinsurance, and benefits otherwise not covered by the major medical coverage. A stand-alone health FSA, which does not meet the criteria for excepted benefits, must satisfy the SBC requirements independently.

On October 1, 2014, the Departments published final rules on excepted benefits.[57] These regulations stated that an EAP constitutes excepted benefits if it satisfies certain

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[55] *See* Affordable Care Act Implementation FAQs Part IX, question 12, available at http://www.dol.gov/ebsa/faqs/faq-aca9.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html.

[56] See 26 CFR 54.9831-1(c), 29 CFR 2590.732(c), 45 CFR 146.145(c).

[57] 79 FR 59130 (October 1, 2014).

requirements.[58] If an EAP qualifies as excepted benefits, the EAP need not separately satisfy the SBC requirements.

The Departments have issued guidance regarding HRAs since the publication of the 2012 final regulations.[59] An HRA is a group health plan. The Departments' guidance on HRAs clarifies that such arrangements are subject to the group market reform provisions of the Affordable Care Act, including the prohibition on annual limits under PHS Act section 2711 and the requirement to provide certain preventive services without cost sharing under PHS Act section 2713. The Departments' guidance further clarifies that such arrangements will not violate the market reform provisions when integrated with a group health plan that complies with those provisions (and that such arrangements cannot be integrated with individual market policies to satisfy the market reforms).

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[58] The first requirement is that the EAP does not provide significant benefits in the nature of medical care. For this purpose, the amount, scope, and duration of covered services are taken into account. (See preamble discussion at 79 FR 59133 for examples). The second requirement is that the EAP's benefits cannot be coordinated with the benefits under another group health plan. For this purpose, participants in the group health plan must not be required to use and exhaust benefits under the EAP (making the EAP a "gatekeeper") before an individual is eligible for benefits under the other group health plan; and participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan. The third requirement is that no employee premiums or contributions may be required as a condition of participation in the EAP. The fourth requirement is that an EAP that constitutes excepted benefits may not impose any cost-sharing requirements.

[59] On September 13, 2013, DOL and the Treasury published guidance on the application of the market reforms and other provisions of the Affordable Care Act to health reimbursement arrangements (HRAs), certain health flexible spending arrangements (health FSAs) and certain other employer health care arrangements. See DOL Technical Release 2013-03, available at http://www.dol.gov/ebsa/newsroom/tr13-03.html, and IRS Notice 2013-54, available at http://www.irs.gov/pub/irs-drop/n-13-54.pdf. HHS also issued guidance to reflect that HHS concurs in the application of the laws under its jurisdiction as set forth in the DOL and Treasury Department guidance. See Insurance Standards Bulletin, Application of Affordable Care Act Provisions to Certain Healthcare Arrangements, September 16, 2013, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cms-hra-notice-9-16-2013.pdf. On May 13, 2013, two FAQs were made available on the IRS website addressing employer healthcare arrangements, available at: www.irs.gov/uac/Newsroom/Employer-Health-Care-Arrangements. On November 6, 2014, the Departments issued three FAQs on the compliance of premium reimbursement arrangements. See ACA Implementation FAQs Part XXII, available at http://www.dol.gov/ebsa/pdf/faq-aca22.pdf and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs22.html.

Benefits under an HRA generally do not constitute excepted benefits, and thus HRAs are generally subject to the SBC requirements. An HRA integrated with other major medical coverage under a group health plan need not separately satisfy the SBC requirements; the SBC is prepared for the other major medical coverage, and the effects of employer allocations to an account under the HRA can be denoted in the appropriate spaces on the SBC, including those for deductibles, copayments, coinsurance, and benefits otherwise not covered by the other major medical coverage.

HSAs generally are not group health plans and thus generally are not subject to the SBC requirements. Nevertheless, an SBC prepared for a high deductible health plan associated with an HSA can (but is not required to) mention the effects of employer contributions to HSAs in the appropriate spaces on the SBC, including those for deductibles, copayments, coinsurance, and benefits otherwise not covered by the high deductible health plan.

V. Applicability Date

Changes to the current requirements to provide an SBC, notice of modification, and uniform glossary under PHS Act section 2715 and the 2012 final regulations are proposed to apply for disclosures with respect to participants and beneficiaries who enroll or re-enroll in group health coverage through an open enrollment period (including re-enrollees and late enrollees) beginning on the first day of the first open enrollment period that begins on or after September 1, 2015. With respect to disclosures to participants and beneficiaries who enroll in group health coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), the requirements of these proposed regulations are proposed to apply beginning on the

(e) Failure to provide. A health insurance issuer or a non-federal governmental health plan that willfully fails to provide information to a covered individual required under this section is subject to a fine of not more than $1,000 for each such failure. A failure with respect to each covered individual constitutes a separate offense for purposes of this paragraph (e). HHS will enforce these provisions in a manner consistent with §§150.101 through 150.465 of this subchapter.

(f) Applicability. The requirements of this section do not apply to a group health plan benefit package that provides Medicare Advantage benefits pursuant to or 42 U.S.C. Chapter 7, Subchapter XVIII, Part C.

[FR Doc. 2014-30243 Filed 12/22/2014 at 4:15 pm; Publication Date: 12/30/2014]