OMB Control No. 0938-1372
Expiration Date: 12/31/2024

APPENDIX 1:

Transparency in Coverage Model Notice

Instructions for the Transparency in Coverage Model Notice

The Departments of the Treasury, Labor, and Health and Human Services (the Departments) have issued the Transparency in Coverage final rules (85 FR 72158) that require non-grandfathered group health plans and health insurance issuers in the individual and group markets to disclose certain cost-sharing information to a participant, beneficiary, or enrollee (or his or her authorized representative), upon request. Under the final rules at 26 CFR 54.9815-2715A2, 29 CFR 2590.715-2715A2, and 45 CFR 147.211, a plan or issuer must provide an estimate of an individual's cost-sharing liability for a covered item or service, including the underlying information necessary to calculate the estimate. The plan or issuer also must provide a notice of required prerequisites for the item or service, and a notice explaining certain limitations that are applicable to the individual's cost-sharing liability estimate.

This model notice satisfies the notice requirements under the final rules with respect to prerequisites and the limitations of the cost-sharing information. A plan or issuer may use this model notice when a participant, beneficiary, or enrollee (or his or her authorized representative) requests cost-sharing information in paper form or may incorporate the language contained in the model notice into the internet-based self-service tool.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The Departments are seeking OMB approval for the model notice as part of the approval for a new OMB control number 0938-1372. The time required to complete this information collection is estimated to average 23,313 hours per respondent to provide notice of any required prerequisites and the limitations of the cost-sharing information made available through a self-service tool and 11 hours per respondent in order to make the notice available in paper form, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Transparency in Coverage Model Notice

Effective Date – 1/2024

You are receiving this notice because you requested a cost estimate for an item or service. This notice contains important information about the cost estimate and information on the amount you may be required to pay for this item or service.

I. The Basics

What should I do with this notice?

Read this notice carefully along with the cost estimate. You may need to request a new cost estimate as you obtain new information, such as information on additional items or services you will receive as part of your diagnosis, treatment, or procedure.

What are the key terms?

1. An **Allowed Amount** is the maximum amount your health plan will pay for a covered item or service furnished by a provider.

2. **Cost Sharing** is your share of costs for a covered item or service that you must pay (sometimes called "out-of-pocket costs"). Some examples of cost sharing are deductibles, coinsurance, and copayments. [*include this if balance billing is permitted under state law*] This term does not include other costs you may be responsible for, such as premiums, balance-billed amounts for out-of-network providers, or the cost of items or services not covered by your health plan.

3. An **Accumulated Amount** is the amount of financial responsibility you have incurred at the time a request for cost-sharing information is made, with respect to a deductible or out-of-pocket limit.

4. A **Covered Item or Service** is an item or service that your health plan will pay for, either in whole or in part, under the terms of your health plan.

5. An **Out-of-Network Provider** is a provider that does not have a contract with your plan to provide the requested items or services at pre-negotiated rates.

6. **Prerequisites** are certain requirements your health plan may impose on you or your provider so that your plan can determine whether a health care item or service, including treatment plans, prescription drugs, or durable medical equipment, is medically necessary before your plan will provide benefits for these items and services. For purposes of this estimate, prerequisites include prior authorization, concurrent review, or fail-first requirements.

Other common medical and insurance terms, including definitions of deductibles, coinsurance, and copayments, can be found in the Uniform Glossary of Coverage and Medical Terms (https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf).

II. Important information about your cost estimate

This estimate is designed to provide you with information about the cost of an item or service before you receive care. However, this estimate has certain limitations that you should consider before making any decision to receive the item or service.

1. If you are treated by an out- of-network provider, after paying the cost-sharing amount determined by your health plan, you may still receive a bill for the difference between the amount the out-of-network provider charges for the item or service and the amount paid by your health plan for that same item or service. This is called balance billing, and this amount is not included in your cost estimate.

2. The actual charge for the item or service may be different than the cost estimate, depending on the actual care you receive. For example, if your physician provides additional services during your visit, your charges could be more than the cost estimate. This is one reason why it is important to discuss with your provider both before and during your visit which items and services you will receive and to request a new cost estimate if new information becomes available.

3. This cost estimate is not a benefit determination or guarantee of coverage for the item or service for which you requested information. For example, your plan may need to determine whether the item or service is medically necessary in your case before making a payment. You should follow your health plan's process for filing a claim for benefits and contact your health plan to help determine if there are any additional requirements that apply to you as part of that process.

4. Your health plan counts third-party payments in the calculation of your accumulated amounts (such as deductible and out-of-pocket maximum amounts).

5. An in-network item or service may not be subject to cost sharing if it is billed as a preventive service.

III. Prior Authorization

A. Precertification

Certain services require precertification from your health benefit plan prior to being performed. Your health benefit plan's Utilization Management Department will evaluate all precertification requests. Failure to obtain required precertification may result in a reduction in payment or nonpayment to the provider for the services or drugs not pre-certified. You may review the standard precertification list by clicking here. Your health benefit plan may also have additional services that require precertification.

B. Referrals

For managed care plans, your health plan may require that you obtain a referral from your Primary Care Provider (PCP) before certain items or services are covered. Failure to obtain a referral before the item or service is provided may result in a denied claim.

C. Concurrent Review

Your health plan may require a review during an ongoing course of treatment to determine whether the plan will continue to cover the item or service. This is called concurrent review. Your health plan may cease covering treatment if you or your provider do not submit this item or service for concurrent review within a specified time period after beginning your treatment or procedure.

D. Fail-first

Your health plan will not pay for higher-cost therapies without evidence that certain lower-cost therapies have not been effective for you (these are known as fail-first policies or step-therapy requirements). You may be required to try a lower-cost alternative before your plan will cover this particular item or service.

IV. What if I need more information? – Please contact the number on the back of your Member ID card.