**Important: We will not offer your group health plan in the upcoming plan year.**

We will automatically enroll group members in a plan that is similar to the current plan, if the group does not choose a new plan. This may change your costs, coverage and providers, so review your options carefully.

Date

Dear [Plan Sponsor or Name],

# Why am I getting this letter?

**Your group’s current health coverage will not be renewed, as it will no longer be offered.** The current coverage will end on [Month Day, Year].

# What your group needs to do:

**To keep your group’s health insurance coverage, your group must choose a new plan with coverage starting by [Month Day, Year] or accept the plan we chose for your group.** This letter explains the options available to you.

If your group buys dental coverage separately, you will get a separate letter about how to renew that coverage.

If your group wants the plan we selected for you, simply pay the plan premium. If not, you can also choose any of our other plans available to you.

**When does your group need to make a decision?**

To have continued health care coverage, your group should have a new health plan in place with coverage starting by [Month Day, Year].

# Options from [Issuer Name]

We have selected a new [Issuer Name] plan for your group that is similar to your current plan. **We will automatically enroll you in [Plan Name] unless you choose another option by [Month Day, Year]**.

The updated premium for this new plan starts in [Month]. The estimated amount your group will pay is $[Dollar amount] each month. [Insert if rate pending approval: However, your rate has not yet been finalized. We will update you if there are changes.] To see information about this rate, go to: <https://fortress.wa.gov/oic/consumertoolkitrt/Search.aspx>. This estimated amount may change, depending on the individuals who actually enroll in the plan.

# [Insert the following sentence, table of plan information and two sentences following the table if the current plan and selected plan are offered by the same carrier or controlling group] Your new health plan may have different [benefits and/or cost sharing], including:

|  |  |  |
| --- | --- | --- |
|  | **Current Plan** | **[Insert upcoming year] Plan** |
| **[List plan and ID]** | **[List plan and ID]** |
| Changes to your benefits | * [For benefit changes, list what the benefits were in the current plan or write “no change.” Use additional lines and bullet points as needed.]
 | * [List changes to benefits or write “no change.” Use additional lines and bullet points as needed.]
 |
| Cost sharing (copays and deductibles) | * [For cost-sharing changes, list what the cost-sharing was in the current plan or write “no change.” Use additional lines and bullet points as needed.]
 | * [List changes in cost sharing, including, but not limited to, any change in metal-level tier, out-of- pocket maximum or deductible, or write “no change.” Use additional lines and bullet points as needed.]
 |

**This list may not include all differences, such as differences in the prescription drugs or providers we cover.** For more information about your new plan, please contact us.

# What should your group consider before deciding to keep or change your plan?

* **Providers:** Your new coverage may have different doctors or hospitals. Call [Carrier name] or visit [Link to provider directory or, if the new plan is offered by another carrier, then a link to that carrier’s our website] to see which doctors and other health care providers are covered.
* **Benefits:** Call [Carrier name] or visit [Link to Benefit Booklet or, if the new plan is offered by another carrier, then a link to that carrier’s our website] for a copy of your new plan’s benefit booklet, which includes a description of benefits and the costs your members pay when they use services.
* **Drugs:** Call [Carrier name] or visit [Link to formulary or, if the new plan is offered by another carrier, then a link to that carrier’s our website] for a copy of your new plan’s drug formulary, which includes a list of covered prescription drugs.

# What other option does your group have?

* Your group can choose to buy a new health plan and buy directly from [Issuer name] or another company or with the help of an agent or broker.

# We are notifying all group enrollees

The law requires us to notify all group enrollees who have this coverage that we will no longer offer it. Because we might not know about other coverage decisions your group has made, enrollees should check with the plan sponsor or administrator about coverage options that might be available through your organization.

# Questions?

* To learn about your plan or other options for health coverage through [Issuer Name], contact [Contact Information, including TTY/TTD and Hours of Operation] or visit [Link to Summary of Benefits and Coverage or, if the selected plan is offered by another carrier, then a link to that carrier’s our website], where you can review the Summary of Benefits and Coverage for the plans.
* Call [Issuer phone number, including TTY/TTD] to request a reasonable accommodation to get this information in an accessible format, like large print, Braille, or audio, at no cost to you.

**Would you like help in another language?**

* [Language taglines per CCIIO Technical Guidance – March 30, 2016, Guidance and Population Data for Exchanges, Qualified Health Plan Issuers, and Web-Brokers to Ensure Meaningful Access by Limited-English Proficient Speakers Under 45 CFR §155.205(c) and

§156.250; Appendix A – Top 15 Non-English Languages by State; Appendix B: Sample Translated Taglines – Languages Are Listed in Alphabetical Order] (*The* ***OIC will allow the Notice and Taglines to be “posted” with forms either by being embedded in the forms, or as an insert enclosed with the forms*.)**