**Important: Your group health coverage is at risk.**

Your group must take action to ensure your group has health coverage.
Choosing a new plan may change your costs, coverage and providers, so review your options carefully.

[Date]

Dear [Plan Sponsor or Name],

# Why am I getting this letter?

We are not offering your group’s current health coverage in the upcoming plan year. The current coverage will end on [Month, Day, Year]. **To have health insurance for your next plan year, your group must choose a new plan.**

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

**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 and starting on [Month Day, Year].

# What plan does [Issuer Name] suggest for your group?

We have suggested a new [Issuer Name] plan for you that is most similar to your group’s current coverage.

**Your group will not be automatically enrolled in this suggested plan. If you would like this plan, your group will need to purchase this plan directly from [issuer name] or through an insurance producer.**

The estimated premium for this group plan is $[Dollar amount] each month. [Insert if plan pending approval: However, the rate for this plan has not yet been finalized. We will update you if you choose this plan and 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 suggested plan are offered by the same carrier or controlling group] Your suggested plan may have different [benefits and/or cost sharing]:

|  |  |  |
| --- | --- | --- |
|  | **Current Plan** | **New Suggested Plan** |
| **[List plan and ID]** | **[List plan and ID]** |
| Changes to your group’s 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.]
 |
| Changes to your group’s cost-sharing  | * [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 this suggested plan, please contact us.

# What should your group consider when shopping for a health plan?

* **Providers:** The suggested plan may have different doctors or hospitals. Call [Carrier name] or visit [Link to provider directory or, if the suggested 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 our website [Link to Benefit Booklet or, if the suggested plan is offered by another carrier, then a link to that carrier’s our website] for a copy of the suggested 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 [direct link to formulary or, if the suggested plan is offered by another carrier, then a link to that carrier’s our website] for a copy of the suggested 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 group health plan 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 the 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 the suggested plan or other options for health coverage through [Issuer Name], contact [Contact Information, including TTY/TDD and Hours of Operation] or visit [Link to Summary of Benefits and Coverage or, if suggested plan is offered by another carrier, then a link to that carrier’s 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*.)**