We Are Continuing Your Employee Health Coverage Group Health Plan Renewed, But Not Automatically

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**Important: Although [Name of Issuer] is continuing to offer your group health plan for the next year,**

**you must take action to keep your health coverage.**

Some plan details may have changed. This may change some of 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 health coverage is coming up for renewal as of [Month Day, Year]. **You can keep your coverage, but it will not auto-renew, so your group must take action.** Read this letter carefully and review your options.

**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].

# If you wish to renew this coverage, please contact your [issuer name] account representative and complete your re-enrollment by [Month Day, Year].

If your group buys dental coverage separately, you will receive a different letter telling you how to renew it.

This letter summarizes any changes to your coverage so you can decide if you want to keep your plan or look for a different one.

The updated premium for this plan starts in [Month]. The estimated amount your group ’will pay is $[Dollar amount] each month. [Insert if plan pending approval: However, your plan 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.

# Changes we’re making to your current health plan:

|  |  |  |
| --- | --- | --- |
|  | **Current Plan Year** | **New Plan Year** |
| [List plan name and ID] | [List plan name 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, changes in out of pocket maximum or deductible), or write “no change.” Use additional lines and bullet points as needed.]
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**This list may not include all changes, such as changes to the prescription drugs or providers we cover.** For full information about changes to your plan, please contact us.

We Are Continuing Your Employee Health Coverage Health Plan Will Be Renewed, But Not Automatically

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

* **Providers:** Your renewed coverage may have different doctors or hospitals. Call [Carrier name] or visit [Link to provider directory or, if the renewal plan is offered by another carrier, then a link to that carrier’s 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 renewal plan is offered by another carrier, then a link to that carrier’s website], for a copy of your renewed 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 renewal plan is offered by another carrier, then a link to that carrier’s website] for a copy of your renewed plan’s drug formulary, which includes a list of covered prescription drugs.

# What if your group wants to change health plans?

Generally, your group can buy coverage any time throughout the year as long as your group has enough members and you contribute enough to their premiums. If group members enroll and the employer pays premiums by the [Day] of the month, coverage can start on the 1st of the following month.

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

# 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 renewal 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*.)**