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

Take action by [Month Day, Year], or your group may not have health coverage.

[Date]

Dear [Plan Sponsor or Name],

# Why am I getting this letter?

**Your group’s current health plan will not be renewed**. And, beginning [Month Day, Year], we won’t offer health insurance coverage in your area. **This means your group must enroll in a new health plan from another company to have coverage beginning [Month Day, Year].** Read this letter carefully and review your options.

# This information does not impact your current coverage. As long as you keep paying your monthly premiums to [Issuer Name], you will still have coverage through [Month Day, Year].

**To keep your group’s health coverage, your group must choose a new plan from another company.**

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

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

**What your group needs to do:**

 Your group can choose to buy a new health plan with the help of an agent or broker or directly from another company.

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

* **Providers**. Health plans through a different company may have different doctors or hospitals from your old plan. Call the company for the new health plan or visit their website to make sure your doctor and other health care providers are covered.
* **Benefits**. You can request to view a company’s health plan benefit booklet, which will include a description of benefits and the costs your members pay when they use services.
* **Drugs**. You can request to view a company’s health plan drug formulary, which will include a list of covered prescription drugs.

**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?

* You can contact [Issuer Name] at [Contact Information, including TTY/TTD and Hours of Operation] or visit [Link to issuer website] for help with any questions.
* Call [Issuer phone number, including TTY/TDD] 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*.)**