*{Drafting note: The name of issuer should be clear in this notice. If the notice is sent on stationery with headings that list an insurance group, the particular issuer within the insurance group should be clearly identified.}*

**Important: We will not offer your health insurance policy next year,**

**but your group has options for new coverage.**

[Date]

Dear [Certificate holder]:

We are writing to let you know that your group’s current health insurance policy will not be available in 2024. The current coverage will end on [date]. [Although we will suggest a replacement policy] [Your; your] [employer; group policy holder] may decide to buy new coverage from any of [Issuer’s] large group policies offered in your service area or may choose coverage from another insurer. Because we may not know about other coverage decisions your [employer; group policy holder] has made, please check with your [employer; group policy holder] about other group coverage options that might be available.

**Your rights:**

• If you are totally disabled at the time your existing [Issuer] group coverage terminates, you may be eligible for a limited extension of your benefits for covered care or treatment of the condition causing your disability. Only care or treatment related to your disabling condition is eligible for this extension of benefits. If you develop a new condition or if you have an accidental injury after your coverage terminates, then that condition or injury will not be covered. Contact [issuer name] to learn about this benefit.

• If you are either: a) in an ongoing course of treatment with a provider for a life-threatening or a degenerative and disabling condition or disease; or b) in the second or third trimester of a pregnancy when your new coverage becomes effective, then you may be able to continue to receive care from your provider for up to 60 days (or through pregnancy including through delivery and any post-partum care directly related to the delivery) under your new health insurance policy, even if your provider does not participate in your new health insurer’s network.

To receive this transitional care, your provider must agree to accept as payment your new health insurer’s reimbursement for such services and to certain other conditions of providing care under the new policy. If your provider agrees, you will receive the services as if they were being provided by a participating provider and you will only pay for any applicable in-network cost-sharing. You, your representative or your provider should contact your new health insurer to determine if you are eligible for transitional care.

**•** If your [employer; group policy holder] does not replace your plan with a similar plan, you may purchase a new individual health insurance policy from us as a direct pay member.

• Please see Attachment A describing certain rights that may be available if you or your dependent have a serious medical condition.

Please call [Issuer toll free number and hours of operation] if you have any questions.

Para obtener asistencia en Español, llame al [Issuer contact information]. *{Drafting note: This statement must appear in Spanish, and may also appear in other languages.}*

[Insert signature of issuer representative]