*{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 [Group policyholder]:

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]. This means in order for your group to have coverage, and to avoid gaps in coverage, **you need to choose a new policy for your [group members; employees] on or before [date].** This letter explains the options available to you.

**Options from [Issuer]:**

*{Drafting note: The following should appear in every notice. Omit the remainder of this section if the issuer does not plan to map the group to another policy.}*

You may choose any small group coverage offered by [Issuer] in your service area. Call [Issuer phone] or visit [Issuer website] to learn about other policies we have available to your group. *{Drafting note: Issuer is permitted to include details here about how to choose a different policy from issuer}*

*{Drafting note: Insert the following sentence when the issuer plans to map the group to a specific policy.}*

[We have selected a new [Issuer] policy for your group that is [the most] similar to your group’s current policy.

**[Issuer] will automatically enroll your [group members; employees] in [replacement policy] unless you choose another option on or before [date].**

Included are key differences between the new coverage and your current coverage. You can review all the benefits and coverage details in a Summary of Benefits and Coverage (SBC) document, as well as provider and formulary lists for both the new policy and your current policy at [Issuer website].

• Premium

*{Drafting note: Issuer may choose the format for presenting premium information either here or in an attachment. The following information must be included:*

*▪ New premium by rate tier*

*▪ To determine the approximate total new premium for your group just multiply your current enrollment by the new premium. (Issuers may wish to include this language: This will provide an estimate based on current enrollment of your group. This amount may change depending on the individuals who actually enroll in the policy.)}*

• Changes to your policy include:

*{Drafting note: List differences between current and new policies either here or in an attachment, including deductibles, maximum out of pocket amounts, PCP/Specialist copays, coinsurance, hospital inpatient cost sharing, and Rx cost sharing for the proposed small group plan}*

If you want this policy, you need only pay the new premium.]

**Other options:**

*{Drafting note: use the first sentence below if the issuer is mapping to new coverage. If the issuer is not mapping, use the second sentence.}*

[You also have the option to purchase new health insurance coverage [either] directly from [[Issuer name] or from][another; an] insurance company, or with the help of a broker or agent.]

[You may also purchase a new policy from another insurance company, either directly from an issuer or with the help of a broker or agent.]

Your group may be eligible for a small business health care tax credit, but you can get that credit **only** if you buy a “SHOP certified” policy. If your employees enroll in a policy certified by the NY State of Health Small Business Marketplace (“SHOP”) offered through a variety of different insurance companies [including [Issuer name; us]], you can request an eligibility determination from SHOP. If you meet all the IRS guidelines, you may be eligible for the small business health care tax credit. You can get that credit only if SHOP determines that you are an eligible employer and only if your employees enroll in a SHOP certified insurance policy. [Please note that [Issuer name] does not offer a SHOP certified policy.]

You can compare SHOP certified policies available in your service area at: [www.nystateofhealth.ny.gov](http://www.nystateofhealth.ny.gov).

**Before you decide:**

Call the insurer or visit the insurer’s website to check which doctors, other healthcare providers and prescription medications are covered by the new policy. This is an important step in selecting a policy that best meets the needs of your group.

**When to buy:**

You generally can buy coverage for a group at any time throughout the year, but to avoid gaps in coverage, you should enroll before [Date].

**Other information:**

A provision in New York Insurance Law known as “Ian’s Law” provides certain rights for individuals who are covered under a group policy that is coming to an end when the covered person has a serious medical condition.[[1]](#footnote-1) Attachment A describes your [group members’; employees’] rights under Ian’s Law.

**Notifying your [group members; employees]:**

Federal and state law require that we notify all [group members; employees] with this coverage that it will no longer be available. Because we might not know about other coverage decisions you have made, we will tell your [group members; employees] to check with you about other coverage options that might be available through your organization. In this notification we will also provide information to [group members; employees] about their rights under Ian’s Law.

In addition, under New York Labor Law and under Insurance Regulations, as a group policyholder you must provide members of the group with notice of the termination of the existing coverage. Attachment B describes your responsibilities.

*{Drafting note: In addition to providing this discontinuance notice to group policyholders, issuers are also required to notify certificate holders of the discontinuance. An issuer may delegate to the group policyholder the distribution of discontinuance notices to the certificate holders, if the group policyholder agrees. If an issuer chooses to delegate the distribution of the discontinuance notice, this notice to the group policyholder should include the following:}*

[Please communicate this information to the individual [group members; employees] who receive coverage through this group policy. If you wish to have [Issuer name; us] notify your [group members; employees] directly, please notify [us; your account representative] within three (3) days of receipt of this notice. A sample notification is enclosed with this mailing. We recommend that you provide any additional information with this notice, such as expected changes in [member; employee] contribution levels, that may help your [group members; employees] better understand their health coverage costs.]

*{Please note, it remains issuer’s responsibility to ensure that the notifications of discontinuance are delivered to certificate holders at least 90 calendar days prior to the termination date of the group policy.}*

**If you have questions:**

**•** Call [Issuer name, contact information and hours of operation] or visit our website at [Issuer website].

• Visit www.nystateofhealth.ny.gov to learn more about the NY State of Health Small Business Marketplace, or call Customer Service at 1-855-355-5777 (TTY: 1-800-662-1220).

**Getting help in other languages:**

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]

1. Insurance Law §§ 3221(p) and 4305(j). [↑](#footnote-ref-1)