Attachment 5: Discontinuation notice for the individual market outside the Exchange and the issuer is not automatically enrolling the enrollee in a different plan

[1 Date]

[2 [First Name][Last Name]
[Address line 1]
[Address line 2] [City][State]
[Zip]]

Important: Your health coverage is ending**. Pick a different plan by [3 Date**], or you won't have health coverage in [4 Year].

Thank you for choosing [5 Issuer] for your health care needs. [6 We're here to help you prepare for Open Enrollment.]

Why am I getting this letter?

Starting [7 Date], we won't offer your current health coverage [8 in your area]. You must enroll in a new plan to keep health coverage. The last day of your current coverage is [9 Date].

Review your coverage options and pick a different plan between [10 Dates]. **Enroll in a different plan by [11 Date] to avoid a gap in your coverage.** If you don't have health coverage, you'll have to pay for all of your health care.

What should I do next?

Choose a different plan.

- Check with [12 Issuer] to see what other plans may be available. You won't get financial help unless you qualify and enroll through [13 Exchange].
- Visit [14 Exchange website] to see [15 Exchange] plans. Compare plans to save money and find one that best meets your needs and budget. Select the Plan name and ID of the plan you want to enroll in.

We're here to help

- Visit [16 Exchange website], or call [17 Exchange phone number] to learn more about [18 Exchange] and find out if you qualify for lower costs.
- Call [19 Issuer] at [20 Issuer phone number] or visit [21 Issuer website].
- Find in-person help from an assister, agent, or broker in your community at [22 Website].
- [23 Contact an agent or broker you've worked with before [24 like Agent/broker name]. [25 Call Agent/broker phone number].]
- [26 Call [27 Issuer phone number] to get this information in an accessible format, like large print, braille, or audio, at no cost to you].

[28 Getting help in other languages]

[29 Insert non-discrimination notice and *taglines consistent with any applicable State or Federal requirements. If there are no such requirements, see required non-discrimination notice and optional taglines.]*

Instructions for Attachment 5 – Discontinuation notice for the individual market outside the Exchange and the issuer is not automatically enrolling the enrollee in a different plan

General instructions:
This notice must be used when the issuer is non-renewing coverage purchased outside the Exchange based on a product discontinuation or there no longer being any enrollee in the plan who live, resides, or works within the product's service area, and not automatically enrolling the enrollee in a different plan. It doesn't need to display the OMB control number.

Item 1. Enter the date of the notice, in format Month DD, YYYY.
Item 2. Enter the full name and address of the primary subscriber. In the individual market, the primary subscriber means the individual who purchases the policy and who is responsible for the payment of premiums.
Item 3. The consumer qualifies for a special enrollment period based on loss of minimum essential coverage. Enter the date by which a plan selection must be made in accordance with 45 CFR 147.104(b)(4)(ii) and 45 CFR 155.420(c)(2) and (c)(5) to avoid a gap in coverage, in format Month DD, YYYY.
Item 4. For discontinuances, non-renewals, or terminations effective at the end of a calendar year, enter the following year, in format YYYY. For discontinuances, non-renewals, or terminations effective at any time other than the end of a calendar year, enter the month and year, in format Month YYYY.
Item 5. Enter the issuer name.
Item 6. Enter the phrase "We're here to help you prepare for Open Enrollment" only if the current policy is terminating on a calendar year basis. Otherwise, omit and skip to item 7.
Item 7. For discontinuances, non-renewals, or terminations effective at the end of a calendar year, enter the following year, in format YYYY. For discontinuances, non-renewals, or terminations effective at any time other than the end of a calendar year, enter the month and year, in format Month YYYY.
Item 8. Enter the phrase "in your area" if non-renewing or terminating based on the fact that there is no longer any enrollee in the plan who lives, resides, or works within the product's service area. Otherwise, omit and skip to item 9.
Item 9. Enter the last day on which the enrollee's current coverage will remain in force, in format Month DD, YYYY.
Item 10. Enter the beginning and end dates of the special enrollment period for the loss of minimum essential coverage or, if such date falls within an annual open enrollment period, enter the end date of the open enrollment period, in format Month DD, YYYY.
Item 11. The consumer qualifies for a special enrollment period based on loss of minimum essential coverage. Enter the date by which a plan selection must be made in accordance with 45 CFR 155.420(b) to avoid a gap in coverage, in format Month DD, YYYY.
Item 12. Enter the issuer name.
Item 13. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Health Insurance Marketplace®."
Item 14. Enter the Exchange website. For a Federally-facilitated Exchange, enter "HealthCare.gov."
Item 15. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."

Item 16. Enter the Exchange website. For a Federally-facilitated Exchange, enter "HealthCare.gov."
Item 17. Enter the Exchange phone number. For a Federally-facilitated Exchange, enter "1-800-318-2596 (TTY: 1-855-889-4325)."
Item 18. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Marketplace."
Item 19. Enter the issuer name.
Item 20. Enter issuer phone number. **Item 21.** Enter issuer website.
Item 22. Enter LocalHelp.HealthCare.gov in a State with a Federally-facilitated Exchange. In other States, enter the appropriate website.
Item 23. Include this phrase if the enrollee has previously used an agent or broker to enroll. Otherwise, omit and skip to item 26.
Item 24. Enter "like" followed by the name of the agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 26.
Item 25. Enter "Call" followed by the phone number of agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 26.
Item 26. This sentence must be included for issuers subject to 1557 of the Affordable Care Act or other applicable Federal or State law and is otherwise encouraged to be included. If this sentence is omitted, skip to item 28.
Item 27. Enter issuer phone number and issuer TTY number.
Item 28. Insert "Getting Help in Other Languages" if adding a tagline pursuant to instruction 29. Otherwise, leave blank.
Item 29. Insert a nondiscrimination notice and taglines consistent with any applicable State or Federal requirements, including Section 1557 of the Patient Protection and Affordable Care Act (Section 1557). If there are no such applicable nondiscrimination requirements, insert the following:

Health insurance issuers are prohibited from employing marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, expected length of life, degree of medical dependency, quality of life, or other health conditions.

Taglines are optional but encouraged for issuers outside the Exchange if they are not otherwise subject to language access standards under applicable Federal or State law, including Section 1557.

If there are no such applicable tagline requirements, the following optional tagline may be inserted:

English: This notice has important information. This notice has important information about your application or coverage through [Issuer]. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call [phone number].

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0935-1254. This information collection is used by issuers in the individual market outside the Exchange to provide notice where coverage is being discontinued and the issuer is not automatically enrolling the enrollee in a different plan. The time required to complete this information collection is estimated to average 4.5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection and provide the notice to individuals. This information collection is mandatory (45 CFR 147.106). This is a third party disclosure, and the issue of confidentiality between third parties is out of scope for the collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850 or Russell.tipps@cms.hhs.gov, Attention: Information Collections Clearance Officer.