Attachment 3: Discontinuation notice for the individual market outside the Exchange and the issuer is automatically enrolling the enrollee in a different plan outside the Exchange

[1 Date]

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

Important: Your plan will no longer be offered next year. **Pick a plan by [3 Date],** or we'll automatically enroll you in a different plan. This may change some of your costs and coverage, so review your options carefully.

Thank you for choosing [4 Issuer] for your health care needs. [5 We're here to help you prepare for Open Enrollment.]

Why am I getting this letter?

Starting [6 Date], we won't offer your current health coverage [7 in your area]. The last day of your current coverage is [8 Date]. Read this letter carefully and review your options.

What's changing in [9 Year]?

Your new plan

We found another plan that may meet your needs. If you don't pick another plan by [10 Date], we'll automatically enroll you in [11 Plan name]. Your coverage in [12 Plan name] will start in [13 Month]. For more information about picking a new plan, go to "What should I do next?" below.

If we automatically enroll you in [14 Plan name], you won't get any financial help lowering your monthly premium or out-of-pocket costs (like deductibles, copayments, and coinsurance).

- To find out if you qualify for these savings and to enroll in a plan through [15 Exchange], visit [16 Exchange website] by [17 Date].

- If you don't enroll in a plan through [18 Exchange] by [19 Date], you may not be able to do so [for 20 Year], even if your finances change.

Your new premium

- **Starting in [21 Month], your [22 estimated] new monthly premium in [23 Plan name] will be $[24 Dollar amount].**

  Important: This is only an estimate based on current information we have. It doesn't reflect any changes to your enrollment, such as adding additional members to your coverage. You'll see your new monthly premium when you get your [25 Month] bill.

- Your [26 Current year] monthly premium is $[27 Dollar amount].

Other changes

- *[28 Briefly describe plan changes and/or refer to enclosed materials]*
- You can review more details about this plan at [29 Issuer website] and in your [30 Year] Summary of Benefits and Coverage at [31 SBC web page].

If you want to pick another plan, enroll by [32 Date] to make sure you have the coverage you want.

What should I do next?

Decide if you want to enroll in [33 Plan name] outside of [34 Exchange] or choose another one.

☐ **I want to enroll in this plan outside of [35 Exchange].**
Pay the monthly premium by [36 Date] and you'll be automatically enrolled.

☐ **I want to pick a different plan.**
You can choose a different plan between [37 Dates]. Enroll by [38 Date] for coverage to start [39 Date].

Here are some ways to find other plans and enroll:

- Check with [40 Issuer] to see what other plans may be available, including whether [41 Plan name] is available on [42 Exchange].
- Visit [43 Exchange website] to find [44 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.
- Remember, you won't get financial help unless you qualify and enroll through [45 Exchange].

We're here to help

- Call [46 Issuer] at [47 Issuer phone number] or visit [48 Issuer website].
- Visit [49 Exchange website], or call [50 Exchange phone number] to learn more about [51 Exchange] and find out if you qualify for lower costs.
- Find in-person help from an assister, agent, or broker in your community at [52 Website].
- [53 Contact an agent or broker you've worked with before [54 like Agent/broker name]. [55 Call Agent/broker phone number].]
- [56 Call [57 Issuer phone number] to get this information in an accessible format, like large print, braille, or audio, at no cost to you.]

[58 Getting help in other languages]

[59 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 3 – Discontinuation notice for the individual market outside the Exchange and the issuer is automatically enrolling the enrollee in a different plan outside the Exchange

General instructions:
This notice must be used when the issuer is non-renewing coverage purchased outside the Exchange as the result of a product discontinuance, and consistent with applicable State law, automatically enrolling the enrollee in different coverage outside the Exchange. This includes non-renewals 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. 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. Enter the date by which a plan selection must be made to avoid automatic re-enrollment, in format Month DD, YYYY.
Item 4. Enter the issuer name.
Item 5. 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 6.
Item 6. 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 7. 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 live, resides, or works within the product's service area. Otherwise, omit and skip to item 8.
Item 8. Enter the last day on which the enrollee's current coverage will remain in force, in format Month DD, YYYY.
Item 9. 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 10. 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) or, if such date falls within an open enrollment period, enter the end date of the open enrollment period, in format Month DD, YYYY.
Items 11 and 12. Enter the plan name for the plan in which the enrollee will be automatically enrolled.
Item 13. Enter the first coverage month under the different plan, in format Month.

Item 14. Enter the plan name for the plan in which the enrollee will be automatically enrolled.
Item 15. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Health Insurance Marketplace®."

Item 16. Enter the Exchange website. For a Federally-facilitated Exchange, enter "HealthCare.gov."
Item 17. Enter the date by which a plan selection must be made, in format Month DD, YYYY.
Item 18. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Marketplace."
Item 19. Enter the date by which a plan selection must be made, in format Month DD, YYYY.
Item 20. For calendar year plans enter the word "for", then the following year, in format YYYY. For non-calendar year plans, enter the phrase "until Open Enrollment."
Item 21. Enter the first month for the following policy year.
Item 22. Include the word "estimated" if the new monthly premium for the following policy year has not yet been finalized at the time of providing the notice.
Item 23. Enter the plan name for the plan in which the enrollee will be automatically enrolled.
Item 24. Enter the amount of monthly premium for the enrollment group for which data are available for the following policy year.
Item 25. Enter the month in which the enrollee will receive their bill with the actual monthly premium for the following policy year.
Item 26. If a calendar year plan, enter the current year, in format YYYY. If a non-calendar year plan, enter the word "current."
Item 27. Enter the most recent amount of monthly premium for the enrollment group for which data are available for the current policy year.
Item 28. List significant plan changes, including but not limited to changes in deductibles, cost sharing, metal level, covered services, eligibility, plan formulary and provider network. This section may refer to enclosed supplemental materials. Do not include the italicized instructions.
Item 29. Enter the issuer website.
Item 30. 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 word "new."
Item 31. Insert SBC web page for the applicable plan.
Item 32. Enter the date by which a plan selection must be made, in format Month DD, YYYY.
Item 33. Enter the plan name for the plan in which the enrollee will be automatically enrolled.
Item 34. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Marketplace."
Item 35. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Marketplace."
Item 36. Enter due date for first premium for following policy year or omit and skip to item 37.
Item 37. 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 open enrollment period, enter the end date of the open enrollment period, in format Month DD, YYYY.
Items 38 and 39. Enter the date by which a plan selection must be made and the corresponding coverage effective date that would result in no gap in coverage between the terminating coverage and the newly selected plan, in format Month DD, YYYY.
Item 40. Enter the issuer name.
Item 41. Enter the plan name for the plan in which the enrollee will be automatically enrolled.
Item 42. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."
Item 43. Enter the Exchange website. For a Federally-facilitated Exchange, enter "HealthCare.gov."

Item 44. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."
Item 45. Enter the Exchange name. For a Federally-facilitated Exchange, enter "Marketplace."
Item 46. Enter the issuer name.
Item 47. Enter issuer phone number.
Item 48. Enter the issuer website.
Item 49. Enter the Exchange website. For a Federally-facilitated Exchange, enter "HealthCare.gov."
Item 50. Enter the Exchange phone number. For a Federally-facilitated Exchange, enter "1-800-318-2596 (TTY: 1-855-889-4325)."
Item 51. Enter the Exchange name. For a Federally-facilitated Exchange, enter "the Marketplace."
Item 52. Enter LocalHelp.HealthCare.gov in a State with a Federally-facilitated Exchange. In other States, enter the appropriate website.
Item 53. Include this phrase if the enrollee has previously used an agent or broker to enroll. Otherwise, omit and skip to item 56.
Item 54. Enter "like" followed by the name of the agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 56.
Item 55. Enter "call" followed by the phone number of agent or broker the enrollee has previously used, if known. Otherwise, omit and skip to item 56.
Item 56. 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 58.
Item 57. Enter issuer phone number and issuer TTY number.
Item 58. Insert "Getting Help in Other Languages" if adding a tagline pursuant to instruction 59. Otherwise, leave blank.
Item 59. 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 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 where coverage is discontinued and the issuer is automatically enrolling the enrollee in a different plan outside the Exchange. The time required to complete this information collection is estimated to average 8 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.