[Date]

[Employee Name]
[Employee Address]
[City, State, Zip Code]

Notice Regarding Your Individual Coverage Health Reimbursement Arrangement (ICHRA)

Dear [Employee Name],

This letter is to formally notify you regarding the Individual Coverage Health Reimbursement Arrangement (ICHRA) offered by [Company Name].

Offer of Coverage:
You are eligible to participate in our ICHRA starting on [Start Date]. This arrangement provides you with a monthly allowance of $[Amount] to help pay for individual health insurance premiums and/or eligible medical expenses.

Requirement to Enroll in Individual Coverage:
To use this ICHRA, you and any covered dependents must be enrolled in individual health insurance coverage (either through the Health Insurance Marketplace or directly from an insurer) or Medicare Parts A and B (or Part C). Coverage cannot be through a spouse's employer-sponsored group plan.

The "Opt-Out" Option:
You have the right to opt out of this ICHRA. If you opt out, you may be eligible for a premium tax credit (PTC) through the Health Insurance Marketplace, provided the ICHRA is considered "unaffordable" under federal guidelines or if you waive the ICHRA entirely.

Important Consequences:
If you accept this ICHRA, you are generally **not** eligible for a premium tax credit for your Marketplace coverage. If you opt out, you may only claim a premium tax credit if the ICHRA is deemed unaffordable based on your household income.

Action Required:
Please indicate your choice below and return this form to [Department/Name] by [Deadline Date].

I accept the ICHRA and attest that I will have individual health insurance coverage.

I decline (opt out of) the ICHRA.

Signature: _____ Date: _____

If you have questions, please contact [HR Contact Name] at [Phone Number/Email].

Sincerely,

[Company Name Management/HR]