Model HIPAA Exemption Election/Election Renewal Document

The following may be submitted on plan sponsor's or plan administrator's letterhead:

Name of Plan: _____

Plan Sponsor: _____

Address: _____

(Not applicable if election document is on letterhead showing the plan sponsor's address.)

EIN: _____ **Plan Number**: (if applicable)

Plan Year/Period of Plan coverage:

(**beginning date**) through (**ending date**)

(may reflect multiple plan years governed by a collective bargaining agreement.)

Plan Administrator:

Address: (If different from plan sponsor's)

(Name of plan, or portion of plan that is self-funded) is not provided through insurance. (Plan sponsor) elects under authority of section 2721(b)(2) of the Public Health Service (PHS) Act, and 45 CFR 146.180 of Federal regulations, to exempt (name of plan or self-funded portion) from the following requirements of title XXVII of the PHS Act (list any or all of the following requirements):

1. Limitations on preexisting condition exclusion periods.

2. Special enrollment periods.

3. Prohibitions against discriminating against individual participants and beneficiaries based on health status.

4. Standards relating to benefits for mothers and newborns.

5. Parity in the application of certain limits to mental health benefits.

6. Required coverage for reconstructive surgery following mastectomies.

This election has been made in conformity with all rules of the plan sponsor, including any public hearing, if required. I certify that the undersigned is authorized to submit this election on behalf of (*name of plan*). A copy of the notice to plan enrollees is enclosed. (In the case of an election renewal, in lieu of enclosing a copy of an updated notice to plan enrollees, the plan sponsor may include a statement that the notice has been, or will be, provided to plan enrollees in accordance with 45 CFR 146.180(f).) If CMS has any questions regarding this election, please contact (*name*) at (*phone number*).

Signature

Title

Model Notice to Enrollees in a Self-Funded Non-Federal Governmental Group Health Plan

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. *(Name of plan sponsor*) has elected to exempt (*name of plan*) from (*all*) (*or specify which ones*) of the following requirements:

[The description of each listed requirement may be omitted.]

1. Limitations on preexisting condition exclusion periods. A preexisting condition exclusion period generally may not exceed 12 months, and generally must be reduced by prior health coverage an individual has had. Also, a plan may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition, nor, under certain conditions, with respect to newborns or children adopted or placed for adoption.

2. Special enrollment periods. Group health plans are required to provide special enrollment periods for individuals who do not enroll in the plan because they have other coverage, but subsequently lose that coverage. Also,

if a plan provides dependent coverage, the plan must provide a special enrollment period for new dependents (and the employee if not already enrolled) within 30 days after a marriage, birth, adoption or placement for adoption.

3. Prohibitions against discriminating against individual participants and beneficiaries based on health status. A group health plan may not discriminate in enrollment rules or in the amount of premiums or contributions it requires an individual to pay based on certain health status-related factors: health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

4. Standards relating to benefits for mothers and newborns Group health plans offering health coverage for hospital stays in connection with the birth of a child generally may not restrict benefits for the stay to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section.

5. Parity in the application of certain limits to mental health benefits Group health plans (of employers that employ more than 50 employees) offering mental health benefits may not set annual or lifetime dollar limits on mental health benefits that are lower than limits for medical and surgical benefits. A plan that does not impose

an annual or lifetime dollar limit on medical and surgical benefits may not impose that type of limit on mental health benefits. These requirements do not apply to benefits for substance abuse or chemical dependency.

6. Required coverage for reconstructive surgery following mastectomies Group health plans that provide medical and surgical benefits for a mastectomy must provide certain benefits in connection with breast reconstruction as well as certain other related benefits.

The exemption from these Federal requirements will be in effect for the (*plan year*)(*period of plan coverage*) beginning (*specify date*) and ending (*specify date*). The election may be renewed for subsequent plan years.

(If the Plan provides protections similar to any of the exempted requirements, either voluntarily or in accordance with State law, identify those protections.)

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another

employer’s health plan, or if you wish to purchase an individual health insurance policy. (If someone will be available to answer questions, an appropriate contact, such as a third party administrator, or personnel office may be identified).