

**Model Notice to Enrollees in a
Self-Funded Nonfederal 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. A 60-day special enrollment period applies to eligible individuals who lose eligibility for Medicaid coverage or coverage under a State child health plan, or who become eligible under Medicaid or a State child health plan for group health plan premium assistance.

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) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

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.

7. Coverage of dependent students on medically necessary leave of absence.

Group health plans are required to continue coverage for up to one year for a dependent child, covered as a dependent under the plan based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution.

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).