

MHPA FORM 1

NOTICE OF GROUP HEALTH PLAN'S EXEMPTION FROM THE MENTAL HEALTH PARITY ACT

\* DESCRIPTION OF THE ONE PERCENT INCREASED COST EXEMPTION – This notice is required to be provided to you under the requirements of the Mental Health Parity Act of 1996 (MHPA) because the group health plan identified in Line 1 below is claiming the one percent increased cost exemption from the requirements of MHPA. Under MHPA, a group health plan offering both medical/surgical and mental health benefits generally can no longer set annual or aggregate lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical/surgical benefits. In addition, a plan that does not impose an annual or aggregate lifetime dollar limit on medical/surgical benefits generally may not impose such a limit on mental health benefits. However, a group health plan can claim an exemption from these requirements if the plan's costs increase one percent or more due to the application of MHPA's requirements.

This notice is to inform you that the group health plan identified in Line 1 below is claiming the exemption from the requirements of MHPA. The exemption is effective as of the date identified in Line 4 below. Since benefits under your group health plan may change as of the date identified in Line 4 it is important that you contact your plan administrator or the plan representative identified in Line 5 below to see how your benefits may be affected as a result of your group health plan's election of this exemption from the requirements of MHPA.

Upon submission of this notice by you (or your representative) to the plan administrator or the person identified in Line 5 below, the plan will provide you or your representative, free of charge, a summary of the information upon which the plan's exemption is based.

1. Name of the group health plan and the plan number (PN): \_\_\_\_\_

2. Name, address, and telephone number of plan administrator responsible for providing this notice:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. For single-employer plans, the name, address, telephone number, (if different from Line 2) and employer identification number (EIN) of the employer sponsoring the group health plan:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Effective date of the exemption (at least 30 days after the notices are sent): \_\_\_\_\_

5. For further information, call: \_\_\_\_\_