

**INSTRUCTIONS FOR MODEL NOTICE**  
(OMB Control Number 1210-0150)

This model notice may, but is not required to, be used by an eligible organization to provide notice to the Secretary of Health and Human Services (HHS) that the eligible organization has a religious objection to coverage of all or a subset of contraceptive services, pursuant to 26 CFR 54.9815-2713A, 29 CFR 2590.715-2713A, and 45 CFR 147.131. The notice may also, but is not required to, be used by an organization to provide updated information to HHS. If the eligible organization establishes or maintains more than one plan, it may submit a separate notice for each plan, or it may modify this form accordingly.

\*Alternatively, an eligible organization may elect to provide notice to HHS without using this model form; or may elect to self-certify using an EBSA Form 700 and send a copy to each health insurance issuer and third party administrator. EBSA Form 700 is accessible at:  
<http://www.dol.gov/ebsa/pdf/preventiveserviceseligibleorganizationcertificationform.pdf>.

After completing this notice or notice in another form for the same purpose, it should be sent by email to HHS at [marketreform@cms.hhs.gov](mailto:marketreform@cms.hhs.gov) or by U.S. mail to:

Centers for Medicare & Medicaid Services  
Center for Consumer Information & Insurance Oversight  
200 Independence Avenue, SW  
Washington, DC 20201  
Room 739H

**Line-by-line instructions:**

**Terminology:** As used in this form, the term “PHS Act” refers to the Public Health Service Act (42 USC 300gg *et seq.*). “ERISA” refers to the Employee Retirement Income Security Act (29 USC 1001 *et seq.*). The “Code” refers to the Internal Revenue Code (26 USA 1, *et seq.*). The “Affordable Care Act” refers to the Patient Protection and Affordable Care Act (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

**Introductory paragraph:** Indicate whether the eligible organization has a religious objection to providing coverage of: (1) all contraceptive services, or (2) a subset of contraceptive services. If the eligible organization objects to providing coverage of a subset of contraceptive services, insert a description of the services sufficient to specifically identify those for which the eligible organization objects to providing coverage.

**Line 1:** Enter the name of the eligible organization and indicate whether it is a non-profit entity or other eligible organization, as described in any applicable regulations and guidance. Insert contact information for the eligible organization, including mailing address, phone, and email (if available).

**Line 2:** In column (a), enter the name of each plan. In columns (b) and (c) enter the plan’s service provider name and contact information, respectively. In column (d), identify whether the service provider is acting as an issuer (by insuring the benefit) or a third party administrator (“TPA”, by providing administrative services only). In column (e), identify if the plan is a church plan, as defined in ERISA section 3(33), or a student health plan, as defined in 45 CFR 147.145(a). If the plan is neither a church plan nor a student health plan, leave column (e) blank. If the eligible organization establishes or maintains a plan with more than one service provider, enter “same” in column (a) and provide information in columns (b), (c), (d), and (e), as applicable.

Line 3: Enter whether the information submitted is original information, or updated information. If the information is updated, specify the date upon which the updated information was, or will be, effective and what has changed (including if the organization no longer meets the criteria to be an eligible organization).

### **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 1210-0150. An organization that seeks to be recognized as an eligible organization that qualifies for an accommodation with respect to the federal requirement to cover certain contraceptive services without cost sharing may complete this model form, may provide notice to HHS without using this model form, or may elect to self-certify using an EBSA Form 700 and send a copy to each health insurance issuer and third party administrator. The self-certification form or notice to the Secretary of Health and Human Services must be maintained in a manner consistent with the record retention requirements under section 107 of the Employee Retirement Income Security Act of 1974, which generally requires records to be retained for six years. The time required to complete this information collection is estimated to average 50 minutes per response, including the time to review instructions, gather the necessary data, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email [ebsa.opr@dol.gov](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0150.

**MODEL NOTICE**

Date: \_\_\_\_\_

To the Secretary of Health and Human Services:

The following eligible organization has a religious objection to providing coverage of  all or  a subset of contraceptive services required to be covered under PHS Act section 2713, as added by the Affordable Care Act, and incorporated into ERISA section 715 and Code section 9815. *If the eligible organization objects to providing coverage of a subset of contraceptive services, insert a description of the services for which the eligible organization objects to providing coverage:*

\_\_\_\_\_.

(1) Name of eligible organization: \_\_\_\_\_

Contact information: \_\_\_\_\_

Eligible organization is a:  Non-profit entity; OR  Other eligible organization

(2) Service provider information:

(a) Plan name	(b) Service provider name	(c) Service provider contact information	(d) Service provider category	(e) Plan type (if applicable)
			<input type="checkbox"/> Issuer or <input type="checkbox"/> TPA	<input type="checkbox"/> Church plan <input type="checkbox"/> Student plan
			<input type="checkbox"/> Issuer or <input type="checkbox"/> TPA	<input type="checkbox"/> Church plan <input type="checkbox"/> Student plan
			<input type="checkbox"/> Issuer or <input type="checkbox"/> TPA	<input type="checkbox"/> Church plan <input type="checkbox"/> Student plan
			<input type="checkbox"/> Issuer or <input type="checkbox"/> TPA	<input type="checkbox"/> Church plan <input type="checkbox"/> Student plan

(3) Information being submitted is (check one):

Original information; OR  Updated information.

*If updated information is being provided, specify the date upon which the updated information was, or will be, effective and what has changed:* \_\_\_\_\_.

\_\_\_\_\_  
Signature of authorized representative of eligible organization

\_\_\_\_\_  
Date

\_\_\_\_\_  
Typed name of authorized representative of eligible organization