DEPARTMENT OF HEALTH & HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES
Office of the Assistant Secretary, Suite 600
370 L'Enfant Promenade, S.W.
Washington, D.C. 20447

ACTION TRANSMITTAL

AT-08-05

DATE: April 11, 2008

TO: State Agencies Administering Child Support Enforcement Plans under Title IV-D of the Social Security Act and Other Interested Individuals

SUBJECT: Distribution of Federally Approved National Medical Support Notice

ATTACHMENT: Attached is a copy of the Federally approved National Medical Support Notice (NMSN) Part A, OMB control number 0970-0222, updated to reflect changes suggested by States experienced in using the previous form and with the new OMB expiration date of March 31, 2011. Also attached is the National Medical Support Notice (NMSN) Part B, OMB control number 1210-0113, which had no changes.

STATUTORY REFERENCE: 45 CFR 303.32 and 29 CFR 2590.609.2. The final rule effective March 27, 2001, implemented provisions of the Child Support Performance and Incentives Act of 1998 (CSPIA), Public Law 105-200. These provisions require State Child Support Enforcement (CSE) agencies, under title IV-D of the Social Security Act, to enforce the health care coverage provision in a child support order, and to use the NMSN to aid enforcement. Tribal IV-D agencies are not required to use these forms.

BACKGROUND: Comments were solicited from the CSE community for form revisions. The NMSN Part A was revised in the following thirty-nine ways:

- **NOTICE TO WITHHOLD FOR HEALTH CARE COVERAGE**

  1) In the Header paragraph, added a new second sentence, "Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable law."

  2) In the Header paragraph, added a new third sentence, "The information on the Custodial Parent and Child(ren) contained on this page is confidential and should not be shared or disclosed with the Noncustodial Parent."

3) In the agency information box, added space for the State "Employer web site."

4) After the Employer, Custodial Parent and Children's Mailing Address lines, deleted the nine open ended parentheses.

5) On the Employer's Name line, after RE, replaced the asterisk (*) with a colon (:).

6) Below the "Substituted Official/Agency Name and Address" line, added (Required if Custodial Parent's mailing address is left blank.)

7) At the bottom of the page, added the new expiration date: 03/31/2011.

- **EMPLOYER RESPONSE**

8) In the first sentence, deleted the word "either."

9) In the first sentence, changed "1, 2 or 3" to "1, 2, 3 or 4."

10) In the third sentence, deleted the words "neither," "nor," and "applies" and modified to read, "If 1, 2, 3 or 4 do not apply, forward Part B…"

11) Added as the fourth sentence, "This includes any organization or labor union that provides group health care benefits to the employee."

12) In the fifth sentence, was modified to read, "Check number 5 and return this **Part A** to the **Issuing Agency** if the Plan Administrator informs you that the child(ren) would be enrolled in or qualify(ies) for an option…"

13) Added as the sixth sentence, "You are required to respond to the Issuing Agency with the **Employer Response** regardless of whether you provide group health benefits or the employee named herein is no longer employed by your organization."

14) Added as the seventh sentence, "Information on the Employer Representative at the bottom of this section is required."

15) Added a new check box # 1 that reads, "The employee named in this Notice has never been employed by this employer."

16) The remaining check boxes have been renumbered: 1 is now 2, 2 is now 3, 3 is now 4, and 4 is now 5.

17) In check box # 2, language was changed to read, "We, the employer, do not maintain or contribute to plans providing dependent or family health care coverage to our employees."

18) In check box # 3, added a second sentence that reads, "Do not check this box if the employee is only temporarily ineligible for health care coverage."

19) At the bottom of the page after "Employer Representative" added the word "(Required)."

20) At the bottom of the page, modified the last sentence, added the word "Federal" before EIN and added the words "Page 1 of this" before the word "Notice."

- **INSTRUCTIONS TO EMPLOYER**

21) In the first paragraph, first sentence, added the word "legal" before the word "Notice."

22) In the first paragraph, third sentence was moved and modified to the third paragraph, fifth sentence.

23) In the second paragraph, first sentence, bolded the word "must."

24) Added a new third paragraph that reads, "An employer receiving this legal Notice is required to complete and return **Part A** if appropriate. If group health coverage is not available to the employee named herein, or the employee was never or is no longer employed, the employer is still required to complete **Part A – Employer Response** and return it to the Issuing Agency with the appropriate response checked. If you, the employer, provide the health care benefits to the employee, forward **Part B – Plan Administrator Response** to the health plan administrator of your organization. If the employee's health care benefits are administered through another organization, including a labor union, forward Part B of the Notice to the labor union or other organization acting as the plan administrator for completion. If the employee has already enrolled the child(ren) in health care coverage, the employer should forward Part B to the plan administrator for completion and submittal to the Issuing Agency."

25) Added a new fourth paragraph that reads, "Keep a copy of **Part A** as it may be used to notify the Issuing Agency at anytime in the future the employee separates from service for any reason including retirement or termination."

- **EMPLOYER RESPONSIBILITIES**

26) In item # 1, first sentence, replaced the word "above" with "in this Notice."

27) In item # 1, first sentence, changed "1, 2, or 3" to "1, 2, 3 or 4."

28) In item # 2(b)(2), changed "4" to "5."

29) In item # 2(c), un-bold the word "of" after "**Part B.**"

- **LIMITATIONS ON WITHHOLDING**

  30) In last paragraph, third sentence changed "4" to "5."

- **PRIORITY OF WITHHOLDING**

  31) In the last sentence, changed "4" to "5."

- **DURATION OF WITHHOLDING**

  32) In the first paragraph, second sentence was modified to read, "Coverage of a child as a dependent will end when conditions for eligibility for coverage under the terms of the plan no longer apply."

  33) In item # 1(a), deleted the word "above" and replaced with "in this Notice."

- **POSSIBLE SANCTIONS**

  34) Added a second sentence that reads, "Sanctions or penalties may be imposed under State law against an employer for failure to respond and/or for non-compliance with this Notice."

- **NOTICE OF TERMINATION OF EMPLOYMENT**

  35) In the second sentence, added the words, "Part A with response 4 checked or…"

- **CONTACT FOR QUESTIONS**

  36) In the first sentence, replaced the word "above" with "at page 1 of this Notice."

  37) Added a new second paragraph that reads, "Indicate below to the Issuing Agency the requested information on your Plan Administrator to whom Part B – Plan Administrator Response is forwarded for completion."

  38) Added at the bottom of the page to read, "Plan Administrator (Required):"

  39) Added fields at the bottom of the page for Plan Administrator information: "Name, Telephone Number, Contact Person, and FAX Number."

SUPERSEDED MATERIAL: AT-05-05, dated February 10, 2005

ACTION REQUIRED: States will need time to make system programming changes to automate the new form. Therefore, please continue to honor the previous form until States are able to implement the revised one. We will make this form available at our web site.

INQUIRIES TO: ACF/OCSE Regional Program Managers

Margot Bean
Commissioner
Office of Child Support Enforcement

cc: Tribal IV-D Agencies

NATIONAL MEDICAL SUPPORT NOTICE
PART A
NOTICE TO WITHHOLD FOR HEALTH CARE COVERAGE

This Notice is issued under section 466(a)(19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974 (ERISA), and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998. Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable law. The information on the Custodial Parent and Child(ren) contained on this page is confidential and should not be shared or disclosed with the Noncustodial Parent.

Issuing Agency: _____ Issuing Agency Address: _____ _____ Date of Notice: _____ Case Number: _____ Telephone Number: _____ FAX Number: _____ Employer web site: _____	Court or Administrative Authority: _____ Date of Support Order: _____ Support Order Number: _____

RE: _____
Employee's Name (Last, First, MI)

_____
Employer/Withholder's Federal EIN Number

_____
Employee's Social Security Number

_____
Employer/Withholder's Name

_____
Employee's Mailing Address

_____
Employer/Withholder's Address

_____
Custodial Parent's Name (Last, First, MI)

_____
Custodial Parent's Mailing Address

_____
Substituted Official/Agency Name and Address
(Required if Custodial Parent's mailing address is left blank)

_____
Child(ren)'s Mailing Address (if different from Custodial Parent's)

_____
_____
_____
Name, Mailing Address, and Telephone Number of a Representative of the Child(ren)

Child(ren)'s Name(s)	DOB	SSN	Child(ren)'s Name(s)	DOB	SSN

The order requires the child(ren) to be enrolled in [ ] any health coverages available; or [ ] only the following coverage(s): __Medical; __Dental; __Vision; __Prescription drug; __Mental health; __Other (specify):_____

THE PAPERWORK REDUCTION ACT OF 1995 (P.L. 104-13) Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. OMB control number: 0970-0222 Expiration Date: 03/31/2011.

EMPLOYER RESPONSE

If 1, 2, 3 or 4 below applies, check the appropriate box and return this Part A to the Issuing Agency within 20 business days after the date of the Notice, or sooner if reasonable. NO OTHER ACTION IS NECESSARY. If 1, 2, 3 or 4 do not apply, forward **Part B** to the appropriate plan administrator(s) within 20 business days after the date of the Notice, or sooner if reasonable. This includes any organization or labor union that provides group health care benefits to the employee. Check number 5 and return this **Part A** to the **Issuing Agency** if the Plan Administrator informs you that the child(ren) would be enrolled in or qualify(ies) for an option under the plan for which you have determined that the employee contribution exceeds the amount that may be withheld from the employee's income due to State or Federal withholding limitations and/or prioritization. You are required to respond to the Issuing Agency by returning this **Employer Response** regardless of whether you provide group health benefits or the employee named herein is no longer employed by your organization. Information on the Employer Representative at the bottom of this section is required.

☐ 1. The employee named in this Notice has never been employed by this employer.

☐ 2. We, the employer, do not maintain or contribute to plans providing dependent or family health care coverage to our employees.

☐ 3. The employee is among a class of employees (for example, part-time or non-union) that are not eligible for family health coverage under any group health plan maintained by the employer or to which the employer contributes. Do not check this box if the employee is only temporarily ineligible for health care coverage.

☐ 4. Health care coverage is not available because employee is no longer employed by the employer:

Date of termination: _____

Last known telephone number: _____

Last known address: _____

New employer (if known): _____

New employer telephone number: _____

New employer address: _____

☐ 5. State or Federal withholding limitations and/or prioritization prevent the withholding from the employee's income of the amount required to obtain coverage under the terms of the plan.

Employer Representative (Required):

Name: _____ Telephone Number: _____

Title: _____ Date: _____

Federal EIN (if not provided by Issuing Agency on Page 1 of this Notice to Withhold for Health Care Coverage): _____

INSTRUCTIONS TO EMPLOYER

This document serves as legal notice that the employee identified on this National Medical Support Notice is obligated by a court or administrative child support order to provide health care coverage for the child(ren) identified on this Notice. This National Medical Support Notice replaces any Medical Support Notice that the Issuing Agency has previously served on you with respect to the employee and the children listed on this Notice.

The document consists of **Part A - Notice to Withhold for Health Care Coverage** for the employer to withhold any employee contributions required by the group health plan(s) in which the child(ren) is/are enrolled; and **Part B - Medical Support Notice to the Plan Administrator**, which **must** be forwarded to the administrator of each group health plan identified by the employer to enroll the eligible child(ren), or completed by the employer, if the employer serves as the health plan administrator.

An employer receiving this legal Notice is required to complete and return **Part A** if appropriate. If group health coverage is not available to the employee named herein, or the employee was never or is no longer employed, the employer is still required to complete **Part A – Employer Response** and return it to the Issuing Agency with the appropriate response checked. If you, the employer, provide the health care benefits to the employee, forward **Part B – Plan Administrator Response** to the health plan administrator of your organization. If the employee's health care benefits are administered through another organization, including a labor union, forward Part B of the Notice to the labor union or other organization acting as the plan administrator for completion. If the employee has already enrolled the child(ren) in health care coverage, the employer must forward Part B to the plan administrator for completion and submittal to the Issuing Agency.

Keep a copy of **Part A** as it may be used to notify the Issuing Agency at anytime in the future the employee separates from service for any reason including retirement or termination.

EMPLOYER RESPONSIBILITIES

1. If the individual named in this Notice is not your employee, or if family health care coverage is not available, please complete item 1, 2, 3 or 4 of the Employer Response as appropriate, and return it to the Issuing Agency. NO FURTHER ACTION IS NECESSARY.

2. If family health care coverage is available for which the child(ren) identified above may be eligible, you are required to:

    a. Transfer, not later than 20 business days after the date of this Notice, a copy of **Part B - Medical Support Notice to the Plan Administrator** to the administrator of each appropriate group health plan for which the child(ren) may be eligible, and

    b. Upon notification from the plan administrator(s) that the child(ren) is/are enrolled, either

        1) withhold from the employee's income any employee contributions required under each group health plan, in accordance with the applicable law of the employee's principal place of employment and transfer employee contributions to the appropriate plan(s), or

        2) complete item 5 of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholding.

c. If the plan administrator notifies you that the employee is subject to a waiting period that expires more than 90 days from the date of its receipt of **Part B** of this Notice, or whose duration is determined by a measure other than the passage of time (for example, the completion of a certain number of hours worked), notify the issuing agency of the enrollment timeframe and notify the plan administrator when the employee is eligible to enroll in the plan and that this Notice requires the enrollment of the child(ren) named in the Notice in the plan.

LIMITATIONS ON WITHHOLDING

The total amount withheld for both cash and medical support cannot exceed ___% of the employee's aggregate disposable weekly earnings. The employer may not withhold more under this National Medical Support Notice than the lesser of:

1. The amounts allowed by the Federal Consumer Credit Protection Act (15 U.S.C., section 1673(b));

2. The amounts allowed by the State of the employee's principal place of employment; or

3. The amounts allowed for health insurance premiums by the child support order, as indicated here:_____.

The Federal limit applies to the aggregate disposable weekly earnings (ADWE). ADWE is the net income left after making mandatory deductions such as State, Federal, local taxes; Social Security taxes; and Medicare taxes. As required under section 2.b.2 of the Employer Responsibilities on prior page, complete item 5 of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholding.

PRIORITY OF WITHHOLDING

If withholding is required for employee contributions to one or more plans under this notice and for a support obligation under a separate notice and available funds are insufficient for withholding for both cash and medical support contributions, the employer must withhold amounts for purposes of cash support and medical support contributions in accordance with the law, if any, of the State of the employee's principal place of employment requiring prioritization between cash and medical support, as described here:_____
_____. As required under section 2.b.2 of the Employer Responsibilities on prior page, complete item 5 of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholdings.

DURATION OF WITHHOLDING

The child(ren) shall be treated as dependents under the terms of the plan. Coverage of a child as a dependent will end when conditions for eligibility for coverage under terms of the plan no longer apply. However, the continuation coverage provisions of ERISA may entitle the child to continuation coverage under the plan. The employer must continue to withhold employee contributions and may not disenroll (or eliminate coverage for) the child(ren) unless:

1. The employer is provided satisfactory written evidence that:

a. The court or administrative child support order referred to in this Notice is no longer in effect; or
b. The child(ren) is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment from the plan; or

2. The employer eliminates family health coverage for all of its employees.

POSSIBLE SANCTIONS

An employer may be subject to sanctions or penalties imposed under State law and/or ERISA for discharging an employee from employment, refusing to employ, or taking disciplinary action against any employee because of medical child support withholding, or for failing to withhold income, or transmit such withheld amounts to the applicable plan(s) as the Notice directs. Sanctions or penalties may be imposed under State law against an employer for failure to respond and/or for non-compliance with this Notice.

NOTICE OF TERMINATION OF EMPLOYMENT

In any case in which the above employee's employment terminates, the employer must promptly notify the Issuing Agency listed above of such termination. This requirement may be satisfied by sending to the Issuing Agency a copy of Part A with response 4 checked or any notice the employer is required to provide under the continuation coverage provisions of ERISA or the Health Insurance Portability and Accountability Act.

EMPLOYEE LIABILITY FOR CONTRIBUTION TO PLAN

The employee is liable for any employee contributions that are required under the plan(s) for enrollment of the child(ren) and is subject to appropriate enforcement. The employee may contest the withholding under this Notice based on a mistake of fact (such as the identity of the obligor). Should an employee contest the withholding under this Notice, the employer must proceed to comply with the employer responsibilities in this Notice until notified by the Issuing Agency to discontinue withholding. To contest the withholding under this Notice, the employee should contact the Issuing Agency at the address and telephone number listed on the Notice. With respect to plans subject to ERISA, it is the view of the Department of Labor that Federal Courts have jurisdiction if the employee challenges a determination that the Notice constitutes a Qualified Medical Child Support Order.

CONTACT FOR QUESTIONS

If you have any questions regarding this Notice, you may contact the Issuing Agency at the address and telephone number listed at page 1 of this Notice.

Indicate below to the Issuing Agency the requested information on your Plan Administrator to whom Part B – Plan Administrator Response is forwarded for completion.

Plan Administrator (Required):

Name: _____ Telephone Number: _____

Contact Person: _____ FAX Number: _____

NATIONAL MEDICAL SUPPORT NOTICE OMB NO. 1210-0113

PART B

MEDICAL SUPPORT NOTICE TO PLAN ADMINISTRATOR

This Notice is issued under section 466(a)(19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974, and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998. Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable law. The rights of the parties and the duties of the plan administrator under this Notice are in addition to the existing rights and duties established under such law.

Issuing Agency: _____ Issuing Agency Address: _____ _____ Date of Notice: _____ Case Number: _____ Telephone Number: _____ FAX Number: _____	Court or Administrative Authority: _____ Date of Support Order: _____ Support Order Number: _____

_____)
Employer/Withholder's Federal EIN Number

_____)
Employer/Withholder's Name

_____)
Employer/Withholder's Address

_____)
Custodial Parent's Name (Last, First, MI)

_____)
Custodial Parent's Mailing Address

_____)
Child(ren)'s Mailing Address (if Different from Custodial Parent's)

_____)
_____)
_____)
Name(s), Mailing Address, and Telephone Number of a Representative of the Child(ren)

RE* _____
Employee's Name (Last, First, MI)

_____
Employee's Social Security Number

_____
Employee's Address

_____
Substituted Official/Agency Name and Address

Child(ren)'s Name(s)	DOB	SSN	Child(ren)'s Name(s)	DOB	SSN

The order requires the child(ren) to be enrolled in [] any health coverages available; or [] only the following coverage(s): __medical; __dental; __vision; __prescription drug; __mental health; __other (specify):_____

PLAN ADMINISTRATOR RESPONSE

(To be completed and returned to the Issuing Agency within 40 business days after the date of the Notice, or sooner if reasonable)

This Notice was received by the plan administrator on_____.

☐ 1. This Notice was determined to be a "qualified medical child support order," on _____. Complete **Response 2 or 3, and 4**, if applicable.

2. The participant (employee) and alternate recipient(s) (child(ren)) are to be enrolled in the following family coverage.

☐ a. The child(ren) is/are currently enrolled in the plan as a dependent of the participant.

☐ b. There is only one type of coverage provided under the plan. The child(ren) is/are included as dependents of the participant under the plan.

☐ c. The participant is enrolled in an option that is providing dependent coverage and the child(ren) will be enrolled in the same option.

☐ d. The participant is enrolled in an option that permits dependent coverage that has not been elected; dependent coverage will be provided.

Coverage is effective as of __/__/____(includes waiting period of less than 90 days from date of receipt of this Notice). The child(ren) has/have been enrolled in the following option: _____. Any necessary withholding should commence if the employer determines that it is permitted under State and Federal withholding and/or prioritization limitations.

☐ 3. There is more than one option available under the plan and the participant is not enrolled. The Issuing Agency must select from the available options. Each child is to be included as a dependent under one of the available options that provide family coverage. If the Issuing Agency does not reply within 20 business days of the date this Response is returned, the child(ren), and the participant if necessary, will be enrolled in the plan's default option, if any: _____.

☐ 4. The participant is subject to a waiting period that expires __/__/____ (more than 90 days from the date of receipt of this Notice), or has not completed a waiting period which is determined by some measure other than the passage of time, such as the completion of a certain number of hours worked (describe here: _____). At the completion of the waiting period, the plan administrator will process the enrollment.

☐ 5. This Notice does not constitute a "qualified medical child support order" because:

☐ The name of the ☐ child(ren) or ☐ participant is unavailable.

☐ The mailing address of the ☐ child(ren) (or a substituted official) or ☐ participant is unavailable.

☐ The following child(ren) is/are at or above the age at which dependents are no longer eligible for coverage under the plan _____ (insert name(s) of child(ren)).

Plan Administrator or Representative:

Name: _____ Telephone Number: _____

Title: _____ Date: _____

Address: _____

INSTRUCTIONS TO PLAN ADMINISTRATOR

This Notice has been forwarded from the employer identified above to you as the plan administrator of a group health plan maintained by the employer (or a group health plan to which the employer contributes) and in which the noncustodial parent/participant identified above is enrolled or is eligible for enrollment.

This Notice serves to inform you that the noncustodial parent/participant is obligated by an order issued by the court or agency identified above to provide health care coverage for the child(ren) under the group health plan(s) as described on **Part B**.

(A) If the participant and child(ren) and their mailing addresses (or that of a Substituted Official or Agency) are identified above, and if coverage for the child(ren) is or will become available, this Notice constitutes a "qualified medical child support order" (QMCSO) under ERISA or CSPIA, as applicable. (If any mailing address is not present, but it is reasonably accessible, this Notice will not fail to be a QMCSO on that basis.) You must, within 40 business days of the date of this Notice, or sooner if reasonable:

(1) Complete Part B - Plan Administrator Response - and send it to the Issuing Agency:

(a) if you checked Response 2:

(i) notify the noncustodial parent/participant named above, each named child, and the custodial parent that coverage of the child(ren) is or will become available (notification of the custodial parent will be deemed notification of the child(ren) if they reside at the same address);

(ii) furnish the custodial parent a description of the coverage available and the effective date of the coverage, including, if not already provided, a summary plan description and any forms, documents, or information necessary to effectuate such coverage, as well as information necessary to submit claims for benefits;

(b) if you checked Response 3:

(i) if you have not already done so, provide to the Issuing Agency copies of applicable summary plan descriptions or other documents that describe available coverage including the additional participant contribution necessary to obtain coverage for the child(ren) under each option and whether there is a limited service area for any option;

(ii) if the plan has a default option, you are to enroll the child(ren) in the default option if you have not received an election from the Issuing Agency within 20 business days of the date you returned the Response. If the plan does not have a default option, you are to enroll the child(ren) in the option selected by the Issuing Agency.

(c) if the participant is subject to a waiting period that expires more than 90 days from the date of receipt of this Notice, or has not completed a waiting period whose duration is determined by a measure other than the passage of time (for example, the completion of a certain number of hours worked), complete Response 4 on the Plan Administrator Response and return to the employer and the Issuing Agency, and notify the participant and the custodial parent; and upon satisfaction of the period or requirement, complete enrollment under Response 2 or 3, and

(d) upon completion of the enrollment, transfer the applicable information on Part B - Plan Administrator Response to the employer for a determination that the necessary employee contributions are available. Inform the employer that the enrollment is pursuant to a National Medical Support Notice.

(B) If within 40 business days of the date of this Notice, or sooner if reasonable, you determine that this Notice does not constitute a QMCSO, you must complete Response 5 of Part B - Plan Administrator Response and send it to the Issuing Agency, and inform the noncustodial parent/participant, custodial parent, and child(ren) of the specific reasons for your determination.

(C) Any required notification of the custodial parent, child(ren) and/or participant that is required may be satisfied by sending the party a copy of the Plan Administrator Response, if appropriate.

UNLAWFUL REFUSAL TO ENROLL

Enrollment of a child may not be denied on the ground that: (1) the child was born out of wedlock; (2) the child is not claimed as a dependent on the participant's Federal income tax return; (3) the child does not reside with the participant or in the plan's service area; or (4) because the child is receiving benefits or is eligible to receive benefits under the State Medicaid plan. If the plan requires that the participant be enrolled in order for the child(ren) to be enrolled, and the participant is not currently enrolled, you must enroll both the participant and the child(ren). All enrollments are to be made without regard to open season restrictions.

PAYMENT OF CLAIMS

A child covered by a QMCSO, or the child's custodial parent, legal guardian, or the provider of services to the child, or a State agency to the extent assigned the child's rights, may file claims and the plan shall make payment for covered benefits or reimbursement directly to such party.

PERIOD OF COVERAGE

The alternate recipient(s) shall be treated as dependents under the terms of the plan. Coverage of an alternate recipient as a dependent will end when similarly situated dependents are no longer eligible for coverage under the terms of the plan. However, the continuation coverage provisions of ERISA or other applicable law may entitle the alternate recipient to continue coverage under the plan. Once a child is enrolled in the plan as directed above, the alternate recipient may not be disenrolled unless:

(1) The plan administrator is provided satisfactory written evidence that either:

(a) the court or administrative child support order referred to above is no longer in effect, or

(b) the alternate recipient is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment from the plan;

(2) The employer eliminates family health coverage for all of its employees; or

(3) Any available continuation coverage is not elected, or the period of such coverage expires.

CONTACT FOR QUESTIONS

If you have any questions regarding this Notice, you may contact the Issuing Agency at the address and telephone number listed above.

Paperwork Reduction Act Notice

The Issuing Agency asks for the information on this form to carry out the law as specified in the Employee Retirement Income Security Act or the Child Support Performance and Incentive Act, as applicable. You are required to give the Issuing Agency the information. You are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Issuing Agency needs the information to determine whether health care coverage is provided in accordance with the underlying child support order. The Average time needed to complete and file the form is estimated below. These times will vary depending on the individual circumstances.

	Learning about the law or the form	Preparing the form
First Notice	1 hr.	1 hr., 45 min.
Subsequent Notices	-----	35 min.