

Health Insurance Assignment Orders and National Medical Support Notices

Background This supplement describes Health Insurance Assignment Orders and National Medical Support Notices and describes location benefit office responsibilities in handling these legal orders.

In some situations, courts order the *employer* of the parent who is eligible for health coverage to enroll the employee's child in a medical, dental, and vision plan and to deduct the premiums from the employee's earnings. This Administrative Supplement describes local benefits offices' responsibilities in handling these orders.

Under state law, these orders are called "health insurance assignment orders" and are governed by California Family Code Sections 3760-3772. In addition, there is also an order called a "National Medical Support Notice." These orders are governed by Family Code section 3773 which concerns cases under Social Security Act Title IV, Part D "Child Support and Establishment of Paternity," in which local child support agencies enforce federal support orders/notices.

Failure to comply with a Health Insurance Assignment Order or a National Medical Support Notice could make the University location liable for health care expenses which would otherwise have been covered by insurance.

These orders may not be used as grounds for refusing to hire a person or for discharging or taking disciplinary action against an employee. Doing so may subject an employer to a civil penalty of up to \$500.

Procedures **1. Identify the order as a California Health Insurance Assignment Order (CHIA) or a National Medical Support Notice (NMSN).**

A Health Insurance Assignment Order or a National Medical Support Notice must directly order an employer to provide health coverage to the employee's child. *A marital dissolution agreement or judgment mentioning that one parent must cover the child (or spouse) is NOT considered a health coverage assignment order.*¹

The form used for a valid Health Insurance Assignment Order is attached ([See FL-470, page 6](#)), as is a copy of a National Medical

¹ A marital dissolution agreement or judgment does not allow employees an exception to UC Group Insurance Regulations (e.g., an employee cannot continue a legally divorced spouse in UC coverage because divorced spouses are not eligible dependents), nor does it provide a PIE to enroll family members who were not previously enrolled (e.g. an employee cannot add a spouse/child who is not currently covered until Open Enrollment). Employees subject to these types of agreements will need to make private arrangements.

Support Notice ([See sample notice, page 8](#)). A court may use the exact attached form or issue a separately drafted order which includes the same type of information. These orders are usually sent by the office of the local District Attorney.

It is important to note that these orders are binding on any existing or future employers of the obligor parent; therefore the University may be served with an order that was initially served on an employee's former employer. Such an order would be binding upon the University.

2. Read the order completely and follow all instructions. Pay special attention to any identified timeframes

The order may include instructions to the employer to deliver a copy of the order to the employee parent or "obligor," including notice of his or her rights under the law to quash the order. It may order the employer to complete forms that provide specified information about the employee parent and his/her health coverages. Additionally, the order may require the University to take steps to commence health coverage for the child within a specified number of days of service of the order, unless we receive notice that the employee has moved to quash the order. You may also be required to send notice of the enrollment to the insurance carrier to ensure the carrier sends enrollment and future mailings to both parents (or the person having custody of the child).

Proof of insurability will not be required.

3. If the employee is not eligible for health benefits, the University is not required to cover the supported child.

In these cases, the location Benefits Office must immediately reply to the order stating that it is not required to cover the supported child since the employee is ineligible for coverage. Usually a form for this purpose is included with the order (see page 11); this form often needs to be completed within specified time frames, measured from receipt of the order.

4. If the employee is not covered by a University medical plan due to an opt-out election, the University should reverse the opt-out election.

Provide the employee and the supported child a Period of Initial Eligibility (PIE) in which to enroll in the health plans for which the employee is eligible. No other dependents will be eligible to enroll. The child may not be enrolled unless the obligor UC employee is also

covered.

5. The child must meet the University of California eligibility rules for family members as contained in the Group Insurance Regulations (i.e., age, non-married status, etc.)

If the child does not meet our eligibility rules, the location Benefits Office must usually send proof of this to the party seeking the assignment. Usually a form for this purpose is included with the order (see page 11); this form usually needs to be completed within specified time frames, measured from receipt of the order.

6. The CHIA or NMSN may order the University to provide coverage by a specific medical and/or dental plan (e.g. fee-for-service) but the employee is covered under another type (e.g. HMO).

If the court-assigned plan is not available where the child resides, the obligor may transfer his coverage (and that of any other covered dependent) to a plan which is available to all members of the family unit. If the court does not make an assignment and the parent is enrolled in a medical/dental plan which is available to the child, the child should be enrolled in that plan. The child may not be enrolled in a different plan from the parent.

7. Deductions for any net premium amount will be on the same basis as our standard procedures,

Any additional monthly net premium incurred for the child's coverage will be deducted from the obligor parent's paychecks on an advance payment basis. There will be no premium for a first month of partial coverage. If the child will be added to the parent's existing medical plan, the associated TIP election will remain in force.

8. Any eligible child who obtains coverage due to a CHIA or NMSN shall not be de-enrolled except by written evidence that the court order is no longer effective.

The obligor parent may not de-enroll the child unless written evidence from the court is provided.

Additionally, the CHIA or NMSN may require that the district attorney's office be notified if it is discovered that a child who is supposed to be covered under a CHIA or NMSN will be dropped. Examples are if the employee is no longer eligible for health benefits and coverage for the employee and coverage for the dependent child will lapse, or if the child covered by the order is no longer eligible for coverage under our plan (for example an over-aged dependent). This

notification should be made on the form provided with the CHIA or NMSN (see page 9). This requirement may require special tracking and handling of the child's enrollments.

Termination of a CHIA or NMSN will constitute a Qualifying Event for the purpose of COBRA Continuation Eligibility.

REPLACE THIS FORM WITH FORM FL-470 UPDATED 1/1/2007. HERE IS LINK:

<http://www.courts.ca.gov/documents/fl470.pdf>

FL-470

ATTORNEY OR PARTY WITHOUT ATTORNEY (<i>Name, state bar number, and address</i>): TELEPHONE NO.: _____ FAX NO.: _____ ATTORNEY FOR (<i>Name</i>): _____	FOR COURT USE ONLY
SUPERIOR COURT OF CALIFORNIA, COUNTY OF _____ STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME:	
MARRIAGE OF PETITIONER: RESPONDENT:	
APPLICATION AND ORDER FOR HEALTH INSURANCE COVERAGE	CASE NUMBER:

APPLICATION

- On (*date*): _____, this court ordered obligor (*name*): _____ to provide health insurance coverage for the children named in the order below.
- a. On (*date*): _____, which is at least 15 days before the filing of this application, I gave written notice to obligor of my intent to seek this order
 by first-class mail by personal service.
OR
b. Obligor has waived the requirement of written notice.
- I ask the court to order the employer or other person providing health insurance coverage to enroll or maintain the children in any health insurance coverage available to the obligor.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

(TYPE OR PRINT NAME)  _____
(SIGNATURE OF APPLICANT)

ORDER FOR HEALTH INSURANCE COVERAGE (ASSIGNMENT)

To employer or other person providing health insurance coverage for obligor (*name*):

Social security number (*if known*):

YOU ARE ORDERED TO

- Begin or maintain health insurance coverage of:
Name of child Date of birth Social security No.

You may deduct any premium or costs from the wages or earnings of obligor.

- If the obligor works for you or if you provide health insurance coverage to obligor, give him or her a copy of this order within 10 days after you receive it.
- If no health insurance coverage is available to the obligor, complete and sign the *Declaration of No Health Insurance Coverage* on the reverse and mail this form within 20 days to the attorney or person requesting the assignment.

Date:

(JUDICIAL OFFICER)

MARRIAGE OF <i>(Last name, first name of each party):</i>	CASE NUMBER:
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DECLARATION OF NO HEALTH INSURANCE COVERAGE	
No health insurance coverage is available to the obligor <i>(name)</i> : because <i>(state reasons)</i> :	
I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date:	
_____	_____
<small>(TYPE OR PRINT NAME AND TITLE)</small>	<small>(SIGNATURE OF EMPLOYER OR PERSON PROVIDING HEALTH INSURANCE)</small>
MAIL A COPY OF THIS DECLARATION WITHIN 20 DAYS TO THE ATTORNEY OR PERSON SEEKING THIS ENROLLMENT (SEE INSTRUCTION NO. 5, BELOW).	

**INSTRUCTIONS
 FOR EMPLOYER OR OTHER PERSON PROVIDING HEALTH INSURANCE**

These instructions apply only to an *Order for Health Insurance Coverage* issued by a court.

1. If the obligor works for you or is covered by health insurance provided by you, you must give him or her a copy of this order within 10 days after you receive it.
2. Unless you receive a motion to quash the assignment, you must take steps to begin or maintain coverage of the specified children within 10 days after you receive this order. The coverage should begin at the earliest possible time consistent with group plan enrollment rules.
3. The obligor's existing health coverage will be replaced only if the children are not provided benefits under the existing coverage where they reside.
4. If the obligor is not enrolled in a plan and there is a choice of several plans, you may enroll the children in any plan that will reasonably provide benefits or coverage where they live, unless the court has ordered coverage by a specific plan.
5. If no coverage is available, complete the *Declaration of No Health Insurance Coverage* at the top of this page and mail the declaration by first-class mail to the attorney or person seeking the assignment within 20 days of your receipt of this order. Keep a copy of the form for your records.
6. If coverage is provided, you must supply evidence of coverage to both parents and to any person having custody of the child.
7. Upon request of the parents or person having custody of the child, you must provide all forms and other documentation necessary for submitting claims to the insurance carrier to the extent you provide them to other covered individuals.
8. You must notify the applicant of the effective date of the coverage of the children.
9. You will be liable for any amounts incurred for health care services that otherwise would have been covered under the insurance policy if you willfully fail to comply with this order. You can also be held in contempt of court. California law forbids your firing or taking any disciplinary action against any employee because of this order.

EMPLOYEE INFORMATION

1. This order tells your employer or other person providing health insurance coverage to you to enroll or maintain the named children in a health insurance plan available to you and to deduct the appropriate premium or costs, if any, from your wages or other compensation.
2. You have 10 days to contest this order. Family Code section 3765 tells you how.
3. Family Code section 3770 tells you how and when to petition the court to end this assignment.

Unless we have a more current version of this letter – and one that is not directed to Livermore or Los Alamos – I would delete.



THOMAS J. ORLOFF
DISTRICT ATTORNEY

OFFICE OF THE DISTRICT ATTORNEY
FAMILY SUPPORT DIVISION
ALAMEDA COUNTY
CALIFORNIA

June 3, 2002

2901 Peralta Oaks Court
Oakland, CA 94605-5319
(510) 639-7290
FAX (510) 639-1664
TOLL FREE: 1-877-625-KIDS (5437)

LAWRENCE LIVERMORE NATIONAL LABORATORY UNIV O
ATTN: PAYROLL MANAGER/SUPERVISOR
ACCOUNTING OFFICE L-435
PO BOX 5001
LIVERMORE CA 94550-9900

RE:
SSN:
FSD No:

Dear Sir/Madam:

Enclosed please find a Notice of a **National Medical Support Notice (NMSN)** which orders you to provide, at the expense of your employee, _____, health insurance coverage, which includes any available medical, dental, vision, prescription drugs, and mental health coverage for the child or children specified. This NMSN was designed to meet the ERISA requirements for a qualified medical child support order (QMCSO) to effect enrollment.

Additionally please find enclosed **California Supplement 1** and **California Supplement 2**.

Please read all the instructions on the **NMSN** and **California Supplements**. The below guidelines may assist you as well:

IF MEDICAL INSURANCE IS AVAILABLE:

In accordance with Section 3766, 3767, 3771, and 3773 of the Family Code of California, please enroll the child/ren. See that page 6 of **NMSN** is completed and returned. Please also see that **California Supplement 1** is completed and returned and that it includes:

- Each insurance carrier's name, address, phone #, and any group or policy number.
- List of the names of all persons covered and the commencement date of coverage.
- All forms and documentation necessary for submitting claims.

IF MEDICAL INSURANCE IS AVAILABLE AND THEN THERE IS A SUBSEQUENT LAPSE IN MEDICAL INSURANCE:

Please retain one copy of **California Supplement 2**. If there is a subsequent LAPSE in coverage, use this form to notify this office of the date coverage ended, the reason for the lapse, and, if the lapse is temporary, the date the coverage is expected to resume.

IF MEDICAL INSURANCE IS NOT AVAILABLE OR IS PRECLUDED BY WITHHOLDING LIMITATIONS:

Complete and return page 2 of **NMSN**.

If you have any questions regarding this matter, please contact our office at (510) 639-7299.

Very truly yours,

THOMAS J. ORLOFF
DISTRICT ATTORNEY

By: Family Support Division Caseworker

Enclosures

NMS1 - 02

California Supplement 2:

(NOTICE OF LAPSE IN HEALTH INSURANCE)

(Please retain in your records. If and when there is a subsequent lapse in health insurance, please complete and return this page to District Attorney, Alameda County, Family Support Division, 2901 Peralta Oaks Court, Oakland, CA 94605)

CASE NAME	CASE NUMBER
CUSTODIAL PARENT: VS. NON-CUSTODIAL PARENT:	FSD#:

NAME OF PARENT EMPLOYEE:

The health insurance previously reported on California Supplement 1 as being available has:

Lapsed Terminated FOR (check one):

a. All persons insured for the following reason (specify):

b. The following person (name):

For the following reason (specify):

Check here if lapse is temporary; and please state the date the coverage is expected to resume: _____

Dated: _____

.....
(Type or Print Name)

(Signature of Employer or Insurance Provider)

NMS1

HERE IS A LINK TO AN UPDATED VERSION OF THIS NOTICE:

http://www.acf.hhs.gov/sites/default/files/programs/css/omb_0970_0222_and_1210_0113.pdf

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

This Notice is issued under section 468(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.

Issuing Agency: DISTRICT ATTORNEY, COUNTY OF ALAMEDA Issuing Agency Address: FAMILY SUPPORT DIVISION 2901 PERALTA OAKS COURT OAKLAND, CALIFORNIA 94605 Date of Notice: 6/3/02 Case Number: 1 Telephone Number: (510) 639-7299 or 1-877-625-5437 (KIDS) FAX Number: (510) 639-3523	Court or Administrative Authority: COUNTY OF ALAMEDA, STATE OF CALIFORNIA Date of Support Order: 6/92 Support Order Number:
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Employer/Withholder's Federal EIN Number: _____ RE: Employee's Name (Last, First, MI): _____

Employer/Withholder's Name: **LAWRENCE LIVERMORE NATIONAL LABORATORY UNIV O** Employee's Social Security Number: _____

Employer/Withholder's Address: **ACCOUNTING OFFICE L-435** Employee's Mailing Address: _____
PO BOX 5001
LIVERMORE CA 94550-9900

Custodial Parent's Name (Last, First, MI): _____ Substituted Official/Agency Name and Address: _____

Custodial Parent's Mailing Address: _____

Children'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: _____

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): **ORDER SERVED 2-27-02, COMPLY IMMEDIATELY**

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: 12/31/2003.

EMPLOYER RESPONSE

If either 1, 2, or 3 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 neither 1, 2, nor 3 applies, forward Part B to the appropriate plan administrator(s) within 20 business days after the date of the Notice, or sooner if reasonable. Check number 4 and return this Part A to the Issuing Agency if the Plan Administrator informs you that the child(ren) is/are enrolled in 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.

- 1. Employer does not maintain or contribute to plans providing dependent or family health care coverage.
- 2. 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.
- 3. Health care coverage is not available because employee is no longer employed by the employer:

Date of termination: _____

Last known address: _____

Last known telephone number: () - _____

New employer (if known): _____

New employer address: _____

New employer telephone number: () - _____

- 4. 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:

Name: _____ Telephone Number: _____

Title: _____ Date: _____

EIN (if not provided by Issuing Agency on Notice to Withhold for Health Care Coverage): _____

INSTRUCTIONS TO EMPLOYER

This document serves as 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).

EMPLOYER RESPONSIBILITIES

1. If the individual named above is not your employee, or if family health care coverage is not available, please complete item 1, 2, or 3 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 4 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 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 **50 %** 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.

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:

CONTACT OUR OFFICE.

DURATION OF WITHHOLDING

The child(ren) shall be treated as dependants under the terms of the plan. Coverage of a child 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 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 above 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.

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 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 above.

**NATIONAL MEDICAL SUPPORT NOTICE
 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 (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 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: DISTRICT ATTORNEY, COUNTY OF ALAMEDA Issuing Agency Address: FAMILY SUPPORT DIVISION 2901 PERALTA OAKS COURT OAKLAND, CALIFORNIA 94605 Date of Notice: 6/3/02 Case Number: Telephone Number: (510) 639-7299 or 1-877-625-5437 (KIDS) FAX Number: (510) 639-3523	Court or Administrative Authority: COUNTY OF ALAMEDA, STATE OF CALIFORNIA Date of Support Order: 6/92 Support Order Number:
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Employer/Withholder's Federal EIN Number:

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

Employer/Withholder's Name:
LAWRENCE LIVERMORE NATIONAL LABORATORY UNIV O
 Employer/Withholder's Address:
**ACCOUNTING OFFICE L-435
 PO BOX 5001
 LIVERMORE CA 94550-9900**

Employee's Social Security Number:

Employee's Mailing Address:

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

Substituted Official/Agency Name and Address:

Custodial Parent's Mailing Address:

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:

This 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): **ORDER SERVED 2-27-02, COMPLY IMMEDIATELY**

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 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.

	<u>Learning about the law or the form</u>	<u>Preparing the form</u>
First Notice	1 hr. ____	1 hr., 45 min.
Subsequent Notices	-----	35 min.