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 (CSPIA). 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. **The information on the Custodial Parent and Child(ren) contained on this page is confidential and should not be shared or disclosed with the employee**. NOTE: For purposes of this form, the Custodial Parent may also be the employee when the State opts to have policies to enforce against the custodial parent.

Notice Date: _____ Issuing Agency: _____ Address: _____ Case Identifier: _____ Telephone Number: _____ Email Address: _____ FAX Number: _____	Court or Administrative Authority: _____ Order Date: _____ Order Identifier: _____ Document Tracking Identifier: _____ Employer web site: _____ See NMSN Instructions: http://www.acf.hhs.gov/programs/css/resource/national- medical-support-notice-form

RE:

_____
Employer/Withholder's Federal EIN Number

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

_____
Employer/Withholder's Name

_____
Employee's Social Security Number

_____
_____
_____

Employer/Withholder's Address

_____
Employee's Mailing Address

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

_____
Substituted Official/Agency Name

_____
_____
_____

Custodial Parent's Mailing Address

_____
_____

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

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

_____
Name and Telephone of a Representative of the Child(ren)

_____
_____
_____

Mailing Address of a Representative of the Child(ren)

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

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

The order requires the child(ren) to be enrolled in ☐ all 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) No persons are required to respond to a collection of information unless it displays a valid OMB control number. The time required to complete this information collection is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete the review of the

information collection. **OMB control number: 1210-0113. OMB Expiration Date: [To Be Inserted].**

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)

Case #_____(to be completed by the issuing agency) This Notice was received by the plan administrator on this date _____.

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

2. ☐ The participant (employee) and alternate recipient(s) (child(ren)) are or will 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:_____ (if plan is insured, provider, policy and group numbers, and addresses for submitting claims, are provided in Addendum Section 1). 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:_____(if plan is insured, see Addendum Section 1).

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 child(ren) identified in the Addendum Section 2 is/are at or above the age at which dependents are no longer eligible for coverage under the plan.

Plan Administrator or Representative:

Name: _____ Telephone Number: _____

Title: _____ Date: _____

Address: _____ Email 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, complete Addendum Section 1 and:

(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); and

(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. You must complete Addendum Section I.

(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. Identify child(ren) at or above the age at which dependents are no longer eligible for coverage under the plan in Addendum Section 2.

(C) Any required notification of the custodial parent, child(ren) and/or participant may be satisfied by sending the party a copy of the Plan Administrator Response, if appropriate. You may choose to furnish these notifications electronically in accordance with the requirements of the Department of Labor's electronic disclosure regulation codified at 29 C.F.R. 2520.104b-1(c).

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) regardless of whether the participant has applied for enrollment in the plan. 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 (Part B, Page 1).

For more information, including Medical Support - FAQs for answers to employers' common questions, *see* https://www.acf.hhs.gov/css/form/national-medical-support-notice-forms-instructions. *See also* Medical Support Enforcement Policy Clarifications, https://www.acf.hhs.gov/css/policy-guidance/medical-support-enforcement-policy-clarifications.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately 30 minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Research and Analysis, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0113. OMB Expiration Date: **[To Be Inserted].** Please do not send the National Medical Support Notice (NMSN) response to these DOL addresses. **You must return the response to the child support agency that issued the NMSN to your organization. The child support agency's contact information is on Page 1, Part B.**

NATIONAL MEDICAL SUPPORT NOTICE – ADDENDUM TO PART B

Notice Date: _____ Issuing Agency: _____ Address: _____ Case Identifier: _____ Telephone Number: _____ Email Address: _____ FAX Number: _____	Court or Administrative Authority: _____ Order Date: _____ Order Identifier: _____ Document Tracking Identifier: _____ Employer web site: _____ See NMSN Instructions: http://www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form

SECTION 1: HEALTH INSURANCE DETAILS

Use section 1-1 through 1-6 to provide the information on the plans in which child (ren) is/are enrolled. Complete all of the following information for each type of health care coverage that the child(ren) is receiving (enrolled in) and attach this document to the completed PLAN ADMINISTRATOR RESPONSE.

SECTION 1-1: MEDICAL INSURANCE **Effective Date of Coverage:** _____

_____ _____ _____
Insurance Provider Name | Group Number | Policy Number

_____ _____
Insurance Provider Claims Address Line 1 | Insurance Provider Claims Address Line 2

_____ _____ _____ _____
Insurance Provider Claims City | State | Zip Code | Phone Number for Claims

Medical Insurance Coverage Also Includes: (Check all that apply)
☐ Dental ☐ Vision ☐ Prescription Drug ☐ Mental Health ☐ Other (Specify): _____

SECTION 1-2: DENTAL INSURANCE **Effective Date of Coverage:** _____

_____ _____ _____
Insurance Provider Name | Group Number | Policy Number

_____ _____
Insurance Provider Claims Address Line 1 | Insurance Provider Claims Address Line 2

_____ _____ _____ _____
Insurance Provider Claims City | State | Zip Code | Phone Number for Claims

SECTION 1-3: VISION INSURANCE **Effective Date of Coverage:** _____

_____ _____ _____
Insurance Provider Name | Group Number | Policy Number

_____ _____
Insurance Provider Claims Address Line 1 | Insurance Provider Claims Address Line 2

_____ _____ _____ _____
Insurance Provider Claims City | State | Zip Code | Phone Number for Claims

SECTION 1-4: PRESCRIPTION DRUG INSURANCE Effective Date of Coverage: _____

_____ _____ _____
Insurance Provider Name Group Number Policy Number

_____ _____
Insurance Provider Claims Address Line 1 Insurance Provider Claims Address Line 2

_____ _____ _____ _____
Insurance Provider Claims City State Zip Code Phone Number for Claims

SECTION 1-5: MENTAL HEALTH INSURANCE Effective Date of Coverage: _____

_____ _____ _____
Insurance Provider Name Group Number Policy Number

_____ _____
Insurance Provider Claims Address Line 1 Insurance Provider Claim Address Line 2

_____ _____ _____ _____
Insurance Provider Claims City State Zip Code Phone Number for Claims

SECTION 1-6: OTHER INSURANCE Effective Date of Coverage: _____

_____ _____ _____
Insurance Provider Name Group Number Policy Number

_____ _____
Insurance Provider Claims Address Line 1 Insurance Provider Claim Address Line 2

_____ _____ _____ _____
Insurance Provider Claims City State Zip Code Phone Number for Claims

SECTION 2: NO LONGER ELIGIBLE CHILDREN DETAILS
Use below section to list child(ren) who are at or above the age at which dependents are no longer eligible for coverage under the plan.

Name (Last, First, Middle)	Gender	Date of Birth	Social Security Number