



Qualified Medical Child Support Orders

U.S. Department of Labor
Employee Benefits Security Administration

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Introduction

A 1993 amendment to the Employee Retirement Income Security Act (ERISA) requires employment-based group health plans to extend health care coverage to the children of a parent-employee who is divorced, separated, or never married when ordered to do so by state authorities. This compliance assistance guide explains these ERISA provisions and describes how a plan can be required to cover a child.

Generally, a state court or agency may require an ERISA-covered health plan to provide health benefits coverage to children by issuing a medical child support order. The group health plan must determine whether the medical child support order is “qualified.” Such an order is referred to as a Qualified Medical Child Support Order (QMCSO). In addition, a state child support enforcement agency may obtain group health coverage for a child by issuing a National Medical Support Notice that the group health plan determines to be qualified.

Group health plan sponsors and administrators will find the information in this booklet useful in understanding the rights and obligations of those involved in child support proceedings and those responsible for administering group health plans.¹

The first section of this booklet provides general questions and answers about Qualified Medical Child Support Orders. The second section answers questions about National Medical Support Notices and the role of state child support enforcement agencies in obtaining health care coverage on behalf of children. A final resource section lists additional resources that may provide useful information about ERISA and obtaining health care coverage and medical care for children.

¹As used in this booklet, the term “group health plan” refers to that term as defined in section 607(1) of ERISA and means generally any welfare plan established or maintained by an employer or employee organization (or both) that provides medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise.

Section 1

This section includes an overview of the ERISA provisions that require group health plans to extend health care coverage to children of eligible participants and beneficiaries, plus general information about the requirements that apply to a Qualified Medical Child Support Order (QMCSO). Questions addressed in this section:

- What is a QMCSO?
- Who can be covered by a QMCSO?
- What information is required for a medical child support order to be qualified?
- Who determines whether a medical child support order is qualified?
- What types of health plans are required to recognize QMCSOs?

Q 1-1: What types of plans are subject to the QMCSO provisions?

The QMCSO provisions apply to “group health plans” subject to the Employee Retirement Income Security Act of 1974 (ERISA). For this purpose, a “group health plan” generally is a plan that both:

- Is sponsored by an employer or employee organization (or both) and provides “medical care” to employees, former employees, or their families.
- “Medical care” means amounts paid for the diagnosis, cure, mitigation, treatment or prevention of a disease; for the purpose of affecting any structure or function of the body; transportation primarily for or essential to such care or services; or for insurance covering such care or services.
- ERISA does not generally apply to plans maintained by: Federal, state or local governments; churches; and employers solely for purposes of complying with applicable workers compensation or disability laws. However, provisions of the Child Support Performance and Incentive Act (CSPIA) of 1998 require church plans to comply with QMCSOs and National Medical Support Notices, and state and local government plans to comply with National Medical Support Notices.

[ERISA §§ 4(b), 609(a) and 607(1), Internal Revenue Code § 213(d), CSPIA § 401(f)]

Q 1-2: What is a QMCSO?

A QMCSO is a medical child support order that:

- Creates or recognizes the right of an alternate recipient to receive benefits for which a participant or beneficiary is eligible under a group health plan or assigns to an alternate recipient the right of a

participant or beneficiary to receive benefits under a group health plan; and

- Is recognized by the group health plan as “qualified” because it includes information and meets other requirements of the QMCSO provisions (see Qs 1–6 and 1-7).

In addition, a properly completed National Medical Support Notice (see Section 2) must be treated as a QMCSO.

[ERISA § 609(a)(2), 609(a)(5)(C)]

Q 1-3: What is a medical child support order?

A medical child support order is a judgment, decree, or order (including an approval of a property settlement) that:

- Is made pursuant to state domestic relations law (including a community property law) or certain other state laws relating to medical child support (see Q1-8); and
- Provides for child support or health benefit coverage for a child of a participant under a group health plan and relates to benefits under the plan.

[ERISA § 609(a)(2), Social Security Act § 1908]

Q 1-4: Must a medical child support order be issued by a state court?

No. Any judgment, decree, or order that is issued by a court of competent jurisdiction or an administrative agency authorized to issue child support orders under state law (such as a state child support enforcement agency) that provides for medical support of a child is a medical child support order.

[ERISA § 609(a)(2)]

Q 1-5: Who can be an alternate recipient?

Any child of a participant in a group health plan who is recognized under a medical child support order as having a right to enrollment under the plan with respect to such participant is an alternate recipient.

[ERISA § 609(a)(2)]

Q 1-6: What information must a medical child support order contain to be a “qualified” order?

A medical child support order must contain the following information in order to be qualified:

- The name and last known mailing address of the participant and each alternate recipient. The order may substitute the name and mailing address of a state or local official for the mailing address of any alternate recipient;
- A reasonable description of the type of health coverage to be provided to each alternate recipient (or the manner in which such coverage is to be determined) ; and
- The period to which the order applies.

[ERISA § 609(a)(3)]

Q 1-7: What other requirements must a medical child support order meet to be a “qualified” order?

An order may not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of certain state laws described in Q1-8 below.

[ERISA § 609(a)(4)]

Q 1-8: What state laws relating to medical child support can be enforced by a QMCSO?

At the time that the QMCSO provisions were added to ERISA, Congress also added section 1908 to the Social Security Act. Section 1908 says that states cannot receive Federal Medicaid funds unless they have in place specific state laws relating to medical child support. States must have laws that require:

- Health insurers to enroll a child under his or her parent's health insurance even if the child was born out of wedlock, does not reside with the insured parent or in the insurer's service area, or is not claimed as a dependent on the parent's Federal income tax return;
- A health insurer to enroll a child pursuant to court or administrative order without regard to the plan's open season restrictions;
- Employers and insurers to comply with court or administrative orders requiring the parent to provide health coverage for a child; and
- Insurers to permit a custodial parent to file claims on behalf of his or her child under the noncustodial parent's health insurance and to make benefit payments to the custodial parent or health care provider.

[ERISA § 609(a)(2), 609(a)(4), Social Security Act § 1908]

Q 1-9: What may a QMCSO do to enforce these state medical child support laws?

If a QMCSO refers to these state laws or requires a plan to comply with the substantive requirements contained in the state laws, the plan must comply with them. For instance, a QMCSO may require a plan to enroll a child before the plan's next open enrollment period.

[ERISA § 609(a)(2), 609(a)(4)]

Q 1-10: Who determines whether a medical child support order is qualified?

The administrator of the group health plan is required to determine whether an order is qualified. The administrator is required to make this determination within a reasonable period of time pursuant to reasonable written procedures that have been adopted by the plan. The administrator must first notify the participant and the alternate recipient when the plan receives a medical child support order and must give them copies of the plan's procedures for determining whether it is qualified. The administrator must notify those parties of its determination whether or not the order is qualified.

[ERISA § 609(a)(5)]

Q 1-11: How long may a plan administrator take to determine whether a medical child support order (other than a National Medical Support Notice) is qualified?

Plan administrators must determine whether a medical child support order is qualified within a reasonable period of time after receiving the order. What is a reasonable period will depend on the circumstances. For example, an order that is clear and complete when submitted should require less time to review than one that is incomplete or unclear. The National Medical Support Notice provisions contain separate, specific time limits on the processing of the Notice by employers and plan administrators (see Qs 2-3 and 2-4).

[ERISA § 609(a)(5)]

Q 1-12: If an order names an employee who is not enrolled in the plan but is eligible to enroll, can the order be a medical child support order within the meaning of the QMCSO provisions?

Yes. An employee who is eligible to enroll is a participant in the plan and thus the order is a medical child support order.

[ERISA §§ 3(7), 609(a)(1)]

Q 1-13: In the case of an employee named in a medical child support order who is not enrolled, what is the plan's obligation?

The plan administrator must determine if the order is qualified and, if so, provide coverage to the child. If the employee is eligible to participate in the plan, the child must be covered. If, as a condition for covering his dependents, the employee must be enrolled, the plan must enroll both.

Q 1-14: If an order names an employee who has not yet satisfied the plan's generally applicable waiting period, can the order be a medical child support order within the meaning of the QMCSO provisions?

Yes. An employee who has not yet satisfied a plan's generally applicable waiting period (such as requiring that the person be employed for a certain number of days or work a certain number of hours before being eligible for benefits) is also a participant in the plan, and the order is a medical child support order.

[ERISA §§ 3(7), 609(a)(1)]

Q 1-15: In the case of an employee named in a medical child support order who has not satisfied the plan's generally applicable waiting period, what is the plan's obligation?

The plan administrator must determine if the order is qualified. If the order is qualified, the administrator should have procedures in place so that the child will begin receiving benefits upon the employee's satisfaction of the waiting period. (See Q2-7)

Q 1-16: If a group health plan does not provide any dependent coverage, may a medical child support order require the plan to provide coverage for a child of a participant pursuant to a QMCSO?

No. As stated in Q1-7, a medical child support order is not qualified if it requires a plan to provide a type or form of benefit or option not otherwise available under the plan. An order may not require a plan to provide dependent coverage when that option is not otherwise available under the plan.

[ERISA § 609(a)(4)]

Q 1-17: In determining whether a medical child support order is qualified, is the plan administrator required to determine whether the order is valid under state law?

No. A plan administrator generally is not required to determine whether the issuing court or agency had jurisdiction to issue an order, whether state law is correctly applied in an order, whether service was properly made on the parties, or whether an individual identified in an order as an alternate recipient is in fact a child of the participant.

Q 1-18: Is a plan administrator required to reject a medical child support order as not qualified if the order fails to include factual identifying information that is easily obtainable by the administrator?

No. In many cases, an order that is submitted to the plan may clearly describe the identity and rights of the parties, but may be incomplete only with respect to factual identifying information within the plan administrator’s knowledge or easily obtained through a simple communication with the alternate recipient’s custodial parent, the participant, or the state child support enforcement agency. For example, an order may misstate the names of the participant or alternate recipients, and the plan administrator can clearly determine the correct names, or an order may omit the addresses of the participant or alternate recipients, and the plan administrator’s records include this information. In such a case, the plan administrator should supplement the order with the appropriate identifying information, rather than rejecting the order as not qualified.

Q 1-19: What is a “reasonable description” of type of coverage to be provided to the child?

The order need only provide a coverage description that enables the plan administrator to determine which of the available options and levels of coverage should be provided to the child. For instance, if an order requires that a child be provided any coverage available under the plan, the plan administrator would determine the coverage available under the plan (e.g., major medical, hospitalization, dental) and provide that coverage to the alternate recipient. However, if the plan offers more than one type of coverage (e.g., an HMO and a fee-for-service option), the order should make clear which should be provided or how the choice is to be made. If the order is unclear, the plan’s procedures may direct the administrator to contact the submitting party, or may provide other selection methods similar to those established for the processing of National Medical Support Notices (see Q2-4). If the plan does not have such procedures, the administrator may have to reject the order.

Q 1-20: If a plan provides benefits solely through an HMO or other managed care organization with a geographically limited benefit area, is the plan required to create and provide comparable benefits to an alternate recipient who resides outside of the HMO's service area?

No. As stated in Q1-7, a medical child support order is not qualified if it requires a plan to provide a type or form of benefit that is not otherwise available under the plan. Requiring a plan that provides benefits solely through a limited-area HMO to provide benefits to alternate recipients outside of the HMO's service area (i.e., on a fee-for-service or any other basis), would be requiring the plan to provide a form of benefit that the plan does not ordinarily provide. On the other hand, if the child is able to come into the HMO's service area for medical care, the plan would be required to provide benefits to the alternate recipient.

[ERISA § 609(a)(4)]

Q 1-21: May a plan provide benefits to a child of a participant pursuant to a medical child support order that is NOT a qualified order?

Nothing in Title I of ERISA would prohibit the plan from providing such coverage pursuant to the terms of any medical child support order, regardless of whether the order satisfies the qualification requirements of section 609(a), provided that the terms of the plan do not otherwise prohibit coverage of the child for any other reasons, such as the child does not reside with the participant, or is not claimed as a dependent on the participant's Federal income tax return.

Q 1-22: If a child is covered by a group health plan pursuant to a QMCSO does the child have any rights to continuation coverage?

Yes. A child covered by a group health plan pursuant to a QMCSO is a beneficiary under the plan. The Internal Revenue Service (which has jurisdiction over such questions related to continuation coverage) has informed the Department that a child covered pursuant to a QMCSO is therefore a “qualified beneficiary” with the right to elect continuation coverage under COBRA, if the plan is subject to COBRA and if the child loses coverage as a result of a qualifying event.

[ERISA §§ 609(a)(7)(A) and 607(3)]

Q 1-23: When must a plan begin to provide coverage to an alternative recipient pursuant to a QMCSO?

It is the view of the Department that following a determination that an order is qualified, the alternate recipient (and the participant, if necessary) must be enrolled as of the earliest possible date following such determination. For example, if an insured plan only adds new participants or beneficiaries as of the first day of each month, that plan would be required to provide coverage to the alternate recipient as of the first day of the first month following the determination that the order is qualified.

As described in Q’s 1-8 and 1-9, the state laws described in section 1908 of the Social Security Act require that when a child is enrolled in a plan pursuant to a court or administrative order, that enrollment be made without regard to open season restrictions.

[Social Security Act § 1908]

Q 1-24: What information should a group health plan make available to parties seeking to obtain health coverage for a child before the plan receives a medical child support order?

It is the view of the Department that Congress intended custodial parents and/or state child support enforcement agencies acting on the child's behalf to have access to plan and participant benefit information sufficient to prepare a QMCSO. Information important for that purpose would include the summary plan description, relevant plan documents, and a description of any particular coverage options, if any, that have been selected by the participant.

The Department believes that Congress did not intend to require parties seeking coverage of a child to first submit a medical child support order to the plan in order to establish rights to information in connection with a child support proceeding. However, a plan administrator may condition disclosure of such information on receiving information sufficient to reasonably establish that the disclosure request is being made in connection with a child support proceeding. A disclosure request from a state child support enforcement agency should be assumed to be made in connection with a child support proceeding.

Q 1-25: What effect does an order that a plan administrator has determined to be a QMCSO have on the administration of the plan?

The plan administrator must act in accordance with the provisions of the QMCSO as if it were part of the plan. In particular, any payment for benefits in reimbursement for expenses paid by an alternate recipient or an alternate recipient's custodial parent or legal guardian must be made to the alternate recipient, custodial parent, or legal guardian.

[ERISA § 609(a)(1), 609(a)(8)]

Q 1-26: If a plan provides that dependents of participants must be enrolled in the same coverage and option as the participant, must an alternate recipient be enrolled in the same coverage and options in which the participant is enrolled?

Yes. Pursuant to section 609, an alternate recipient under a QMCSO is treated as a beneficiary under the plan. Accordingly, in the view of the Department, an alternate recipient is also treated as a dependent of the participant under the plan. (However, if a QMCSO specifies that an alternate recipient is to receive a particular level of coverage, or option, that is available under the plan, but the participant is not enrolled in the particular coverage or has not selected the particular option, the plan may be required to change the participant's enrollment to the extent necessary to provide the specified coverage to the alternate recipient.)

[ERISA § 609(a)(7)(A)]

Q 1-27: If the plan requires additional employee contributions or premiums for coverage of a child named in a QMCSO, who is obligated to pay that additional amount?

The medical child support order will ordinarily establish the obligations of the parties for the child's support. In most cases, the obligor under a medical child support order will be the noncustodial parent who is a participant in a group health plan and is responsible for the payment of any costs associated with the provision of coverage.

Q 1-28: What is the plan’s obligation in the event that the employer is unable to withhold from the participant’s paycheck the employee contributions necessary to provide coverage to the child?

If Federal or state withholding limitations prevent withholding from the participant’s paycheck the additional contribution required to provide coverage to the child under the terms of the plan, the employer should notify the custodial parent, and the child support enforcement agency, if the agency is involved. Unless the employer is able to withhold the necessary contribution from the participant’s paycheck, the plan is not required to extend coverage to the child. However, the custodial parent or the agency may be able to modify the amount of cash support to be provided, in order to enable the employer to withhold the required contribution to the plan. The participant may also voluntarily consent to the withholding of an amount otherwise in excess of applicable withholding limitations.

Q 1-29: To whom should the plan pay benefits?

The plan should pay benefits to the alternate recipient, the custodial parent, or the provider of health services to the child notwithstanding plan terms that may require benefit payments be made to the participant. In some instances, payment will be required to be made to the state child support enforcement or Medicaid agency.

[ERISA §§ 609(a)(8), 609(a)(9), 609(b)(3), Social Security Act § 1908(a)(5)]

Q 1-30: When and under what conditions may a plan disenroll an alternate recipient?

A plan may disenroll an alternate recipient at the same time and under the same conditions as it can disenroll other dependents of participants under the plan. For instance, if the plan terminates coverage when a participant terminates employment, and neither the participant nor the alternate recipient elect COBRA continuation coverage, the plan may discontinue coverage for the alternate recipient. Similarly, if the plan ceases to provide coverage for dependents who are over the age of 26, the coverage of an alternate recipient who is over the age of 26 may be terminated (assuming that continuation coverage is not elected).

Section 2

This section discusses the National Medical Support Notice (Notice), which should be used by state child support enforcement agencies to secure coverage for children under their noncustodial parents' group health plans. The following subjects are addressed:

- What constitutes a National Medical Support Notice?
- What is the role of a state child support enforcement agency?
- What obligations do an employer and plan administrator have when they receive a National Medical Support Notice?
- How does an appropriately completed Notice satisfy the QMCSO requirements?

Q 2-1: What is the National Medical Support Notice?

The National Medical Support Notice (Notice) is a standardized medical child support order that is to be used by state child support enforcement agencies to enforce medical child support obligations. The Department of Labor and the Department of Health and Human Services regulations implementing the National Medical Support Notice provisions of the Child Support Performance and Incentive Act of 1998 (CSPIA) appear at 29 CFR § 2590.609- 2 and 45 CFR § 303.32. CSPIA also requires plans sponsored by churches and state and local governments to provide benefits in accordance with the requirements of an appropriately completed Notice, although the Department of Labor has no interpretive or enforcement authority over those requirements. For questions with respect to these plans, contact your state child support enforcement agency.

[ERISA § 609(a)(5)(C), Social Security Act § 466(a)(19)]

Q 2-2: What is the obligation of a state child support enforcement agency regarding the Notice?

Pursuant to the changes made by CSPIA to the child support enforcement program and the regulations issued by the Department of Health and Human Services, the Notice is the exclusive document to be used by a child support enforcement agency to enforce the provision of health care coverage for children of noncustodial parents who are required to provide health care coverage through any employment-related group health plan pursuant to a child support order and for whom the employer is known to the agency.

[Social Security Act § 466(a)(19), 45 CFR § 303.32, CSPIA § 401(e) and (f)]

Q 2-3: What are an employer’s obligations when it receives a National Medical Support Notice?

Ordinarily, an employer may expect to receive a Notice when a child support enforcement agency initially enforces an employee’s medical support obligation, or when an employee with a previously established medical support obligation is newly hired. The Notice is comprised of Part A, Notice to Withhold for Health Care Coverage (which includes an Employer Response) and Part B, Medical Support Notice to Plan Administrator (which includes a Plan Administrator Response).

- If the employee named in the Notice is not an employee of the employer, if the employer does not maintain or contribute to a plan that provides dependent coverage, or if the named employee is among a class of employees (e.g. part-time or non-union) not eligible for enrollment in a plan that provides dependent coverage, the employer must check the appropriate box on the Employer Response and return it to the issuing agency within 20 business days after the date of the Notice (or sooner if reasonable).
- Otherwise, the employer must transfer Part B of the Notice to the group health plan (or plans) for which the child may be eligible for enrollment not later than 20 business days after the date of the Notice.

For these purposes, the “date of the Notice” means the date that is indicated as such on the Notice.

If the employer offers a number of different types of benefits (e.g. dental, prescription) through separate plans, and the issuing agency has not specified which or all are covered by the Notice, the employer should assume all plans are covered by the Notice, and send copies of Part B of the Notice to each plan administrator.

The application of a waiting period (such as one requiring that a new employee must be employed for a certain amount of time or work a certain number of hours) before an employee may enroll in the group health plan does not affect the employer's obligation to transfer Part B to the plan administrator(s).

When transferring Part B of the Notice, the employer retains Part A. An employer that transfers Part B of the Notice to a plan administrator(s) may later need to use the Employer Response after it has been notified of the qualification of the Notice and has determined that necessary employee contributions cannot be withheld from wages.

[Social Security Act § 466(a)(19), 45 CFR § 303.32(c)]

Q 2-4: What are a plan administrator's obligations upon receipt of a National Medical Support Notice?

A plan administrator who receives a National Medical Support Notice must review the Notice and determine whether it is appropriately completed. The administrator must complete the Plan Administrator Response (included with Part B of the Notice), indicating whether the Notice is a QMCSO, and return it to the state agency that issued the Notice within 40 business days after the date of the Notice.

If the plan administrator determines that the Notice is appropriately completed, the administrator is required to treat the Notice as a QMCSO. The plan administrator in that case must inform the state agency that issued the Notice when coverage under the plan of the child named in the Notice will begin. The plan administrator also must provide the custodial parent of the child (or, in some cases, a named state official) with information about the child's coverage under the plan, such as the plan's summary plan description, any forms or documents necessary to make claims under the plan, etc.

If the participant is not enrolled and there is more than one option available under the plan for coverage of the child, the plan administrator

must also use the Plan Administrator Response to notify the agency of that fact, and inform them of the available options for coverage. If the agency does not then respond within 20 business days and the plan has a “default option,” the plan administrator may enroll the child in the default option.

The Department of Labor has issued a regulation, 29 CFR 2590.609-2, that provides guidance for how administrators of group health plans must deal with Notices they receive.

[ERISA § 609(a)(5)(C), 29 CFR § 2590.609-2]

Q 2-5: What is an “appropriately completed” National Medical Support Notice?

An “appropriately completed” Notice is a notice that includes the following information:

- The name of an issuing state child support enforcement agency;
- The name and mailing address of the employee, enrolled or eligible for enrollment, who is obligated by a state court or administrative order to provide medical support for each named child; and
- The name and mailing address of each child covered by the Notice. The name and address of a state or local official may be substituted for the address of the child.

A notice may be “appropriately completed” even if some items of information in the Notice are not included as long as the Notice includes the information listed above. In addition, if any of the necessary information described above has been omitted but is reasonably available to the plan administrator, the Notice should not fail to be “appropriately completed” solely because of such omission.

Q2-6: How does a National Medical Support Notice satisfy the QMCSO requirements?

An “appropriately completed” Notice satisfies the informational requirements of the QMCSO provisions by:

- Providing the name and last known mailing address (if any) of the participant and the name and mailing address of each child covered by the order;
- Having the child support enforcement agency identify either the specific type of coverage or all available group health coverage;
- Instructing the plan administrator that if a Notice does not designate either specific type(s) of coverage or all available coverage, it should assume that all are designated, and further instructing the plan administrator that if a group health plan has multiple options and the participant is not enrolled, the agency will make a selection after the Notice is qualified and, if the agency does not respond within 20 business days, the child will be enrolled under the plan’s default option if there is one; and
- Specifying that the period of coverage may end for the named child only when similarly situated dependents are no longer eligible for coverage under the terms of the plan, or upon the occurrence of events specified in the Notice.

A Notice also requires the plan to provide to a named child only those benefits that the plan provides to any dependent of a participant who is enrolled in the plan, and any other benefits that are necessary to meet the requirements of the state laws relating to medical child support described in Q1-8.

Q 2-7: What if the noncustodial parent is not yet eligible to enroll because he/she has not satisfied the plan's generally applicable waiting period?

As noted above in Q1-14, a plan administrator may not find a medical child support order, including a Notice, to be not qualified solely because the participant is subject to a waiting period (such as one requiring a certain number of months or hours worked). A waiting period may, however, affect the procedures necessary for enrollment of the named child.

Q 2-8: What are the duties of an employer that has been notified of the qualification of a National Medical Support Notice?

Following notification of qualification, the employer must determine if necessary employee contributions may be withheld from the employee's wages without violating any applicable withholding limits. Part A of the Notice contains information for the employer regarding Federal and state limitations on withholdings, any applicable withholding prioritization laws, and the duration of the withholding obligation. If withholding limits would prevent the employer from withholding the employee contributions necessary for coverage, the employer must use the Employer Response on Part A to notify the issuing IV-D Agency of its inability to withhold the necessary amounts. If the amounts necessary for coverage may be withheld, then the employer must initiate such withholding and transmit the withheld amounts to the group health plan to pay for the child's coverage.

Q 2-9: Who pays for coverage provided pursuant to a National Medical Support Notice?

The Notice provides that the employee named in the Notice is liable for any employee contributions required under the plan for enrollment of the children. However, if Federal or state withholding limitations prevent the withholding of the required employee contributions from

the employee's paycheck, the plan is not required to provide coverage to the child. The employer is required to notify the state agency if such withholding limitations prevent the withholding of the required employee contributions. (See Qs 1-25 and 1-26).

Section 3

The following information about ERISA and other laws may be useful sources of information about obtaining health care coverage and medical care for children:

Employee Benefits Security Administration - More information about ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act, and other health benefits laws can be found at EBSA's Website. The Website also contains links to other sites with information about various health care issues.

Two agencies in the Department of Health and Human Services play significant roles in the provision of health care coverage to children:

Office of Child Support Enforcement - The Office of Child Support Enforcement is responsible for establishing standards and providing guidance for the Child Support Enforcement Program under Title IV-D of the Social Security Act.

Centers for Medicare and Medicaid Services - The Centers for Medicare and Medicaid Services administers Medicaid and the State Children's Health Insurance Program (also known as SCHIP), and provides additional guidance under HIPAA, the Affordable Care Act, and other recently enacted health-related laws.

National Child Support Enforcement Association - The National Child Support Enforcement Association (NCSEA) is a nonprofit membership organization comprised primarily of state and local child support enforcement agencies, as well as staff and management of state child support enforcement agencies.

Eastern Regional InterState Child Support Association and **Western InterGovernmental Child Support Enforcement Council** - The Eastern Regional InterState Child Support Association (ERICSA) and the Western InterGovernmental

Child Support Enforcement Council (WICSEC) are child support enforcement professional organizations focusing on issues of interstate child support enforcement.

Each state has a child support enforcement agency. Sometimes this agency is located in the state attorney general's office, but it is frequently found as part of the state's department of social or human services.

Appendix

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 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 page 4, 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 page 4, complete item 5 of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholdings.

Additional Information for Termination Order/Notice (Optional)

1. Effective date of medical support termination: _____
2. Reason for termination: _____
3. Child(ren) to be terminated:

Child(ren)'s Name(s) (Last, First, Middle)	DOB
_____	_____
_____	_____
_____	_____

EMPLOYER RESPONSE

If 1, 2, 3, 4 or 5 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 through 5 does not apply, complete item 7 and 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 for the Plan Administrator and 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 offer our employees the option of purchasing dependent or family health care coverage as a benefit of their employment.
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 not employed by employer:
- Effective date of termination: _____
Reason for 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.
6. 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.
7. Employer forwarded Part B to Plan Administrator on _____.

MM/DD/YY

CONTACT FOR QUESTIONS

Plan Administrator Name: _____	FAX Number: _____
Contact Person: _____	Telephone Number: _____
Employer Name: _____	Telephone Number: _____
Employer Representative Name/Title: _____	Federal EIN: _____
Employee Name: _____	(if not provided on Page 1 of this Notice)
	Date: _____

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 – Employer Response**. 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 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 if 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 the family health care coverage is not available, please complete item 1, 2, 3, 4 or 5 of the Employer Response as appropriate, and return it to the Issuing Agency. **NO OTHER 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, complete item 7, 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), complete item 6 of the Employer Response to 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.
3. If the Termination Order/Notice (Optional) checkbox is checked, you are required to terminate the health care coverage for the child(ren) identified in the order unless the employee has indicated that they want to continue coverage voluntarily.

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 on page 1 of this Notice.

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 enforce against the Custodial Parent.

Issuing Agency: _____ Issuing Agency Address: _____ _____ Notice Date: _____ CSE Agency Case Identifier: _____ Telephone Number: _____ 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
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_____ 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 and Telephone of a Representative of the Child(ren) <table style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <th style="width: 25%;">Child(ren)'s Name(s)</th> <th style="width: 10%;">Gender</th> <th style="width: 10%;">DOB</th> <th style="width: 10%;">SSN</th> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>	Child(ren)'s Name(s)	Gender	DOB	SSN	_____	_____	_____	_____	_____	_____	_____	_____	RE: _____ _____ Employee's Name (Last, First, MI) _____ Employee's Social Security Number _____ _____ Employee's Mailing Address _____ Substituted Official/Agency Name _____ _____ Substituted Official/Agency Name (Required if Custodial Parent's mailing address is left blank) _____ _____ Mailing Address of a Representative of the Child(ren) <table style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <th style="width: 25%;">Child(ren)'s Name(s)</th> <th style="width: 10%;">Gender</th> <th style="width: 10%;">DOB</th> <th style="width: 10%;">SSN</th> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>	Child(ren)'s Name(s)	Gender	DOB	SSN	_____	_____	_____	_____	_____	_____	_____	_____
Child(ren)'s Name(s)	Gender	DOB	SSN																						
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Child(ren)'s Name(s)	Gender	DOB	SSN																						
_____	_____	_____	_____																						
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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. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form please write to: Joseph Piacentini, Office of Policy and Research, Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue NW, Room-N5718, Washington, DC 20210 or email ebssa.opr@dol.gov and reference the OMB Control Number.

OMB control number: 1210-0113. Expiration Date: 10/31/2022.

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 _____.

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 (if plan is insured, identify provider, policy and group numbers): _____. 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 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.

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 20 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 Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebasa.opr@dol.gov and reference the OMB Control Number 1210-0113. Expiration Date: 10/31/2022

29 CFR 2590.609-2 National Medical Support Notice.

(a) This section promulgates the National Medical Support Notice (the Notice), as mandated by section 401(b) of the Child Support Performance and Incentive Act of 1998 (Pub. L. 105-200). If the Notice is appropriately completed and satisfies paragraphs (3) and (4) of section 609(a) of the Employee Retirement Income Security Act (ERISA), the Notice is deemed to be a qualified medical child support order (QMCSO) pursuant to ERISA section 609(a)(5)(C). Section 609(a) of ERISA delineates the rights and obligations of the alternate recipient (child), the participant, and the group health plan under a QMCSO. A copy of the Notice is available on the Internet at <http://www.dol.gov/dol/pwba>.

(b) For purposes of this section, a plan administrator shall find that a Notice is appropriately completed if it contains the name of an Issuing Agency, the name and mailing address (if any) of an employee who is a participant under the plan, the name and mailing address of one or more alternate recipient(s) (child(ren) of the participant) (or the name and address of a substituted official or agency which has been substituted for the mailing address of the alternate recipient(s)), and identifies an underlying child support order.

(c) (1) Under section 609(a)(3)(A) of ERISA, in order to be qualified, a medical child support order must clearly specify the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such alternate recipient. Section 609(a)(3)(B) of ERISA requires a reasonable description of the type of coverage to be provided to each such alternate recipient, or the manner in which such type of coverage is to be determined. Section 609(a)(3)(C) of ERISA requires that the order specify the period to which such order applies.

(2) The Notice satisfies ERISA section 609(a)(3)(A) by including the necessary identifying information described in Sec. 2590.609-2(b).

(3) The Notice satisfies ERISA section 609(a)(3)(B) by having the Issuing Agency identify either the specific type of coverage or all available group health coverage. If an employer receives a Notice that does not designate either specific type(s) of coverage or all available coverage, the employer and plan administrator should assume that all are designated. The Notice further satisfies ERISA section 609(a)(3)(B) by instructing the plan administrator that if a group health plan has multiple options and the participant is not enrolled, the Issuing Agency will make a selection after the Notice is qualified, and, if the Issuing Agency does not respond within 20 days, the child will be enrolled under the plan's default option (if any).

(4) Section 609(a)(3)(C) of ERISA is satisfied because the Notice specifies that the period of coverage may only end for the alternate recipient(s) when similarly situated dependents are no longer eligible for coverage under the terms of the plan, or upon the occurrence of certain specified events.

(d) (1) Under ERISA section 609(a)(4), a qualified medical child support order may not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act, 42 U.S.C. 1396g-1.

(2) The Notice satisfies the conditions of ERISA section 609(a)(4) because it requires the plan to provide to an alternate recipient only those benefits that the plan provides to any dependent of a participant who is enrolled in the plan, and any other benefits that are necessary to meet the requirements of a State law described in such section 1908.

(e) For the purposes of this section, an "Issuing Agency" is a State agency that administers the child support enforcement program under Part D of Title IV of the Social Security Act.

*The current Web address is <https://www.dol.gov/agencies/ebsa>.

45 CFR 303.32 National Medical Support Notice.

(a) Mandatory State laws. States must have laws, in accordance with section 466(a) (19) of the Act, requiring procedures specified under paragraph (c) of this section for the use, where appropriate, of the National Medical Support Notice (NMSN), to enforce the provision of health care coverage for children of noncustodial parents who are required to provide health care coverage through an employment-related group health plan pursuant to a child support order and for whom the employer is known to the State agency.

(b) Exception. States are not required to use the NMSN in cases with court or administrative orders that stipulate alternative health care coverage to employer-based coverage.

(c) Mandatory procedures. The State must have in effect and use procedures under which:

- (1) The State agency must use the NMSN to transfer notice of the provision for health care coverage of the child(ren) to employers.
- (2) The State agency must transfer the NMSN to the employer within two business days after the date of entry of an employee who is an obligor in a IV-D case in the State Directory of New Hires.
- (3) Employers must transfer the NMSN to the appropriate group health plan providing any such health care coverage for which the child(ren) is eligible (excluding the severable Notice to Withhold for Health Care Coverage directing the employer to withhold any mandatory employee contributions to the plan) within twenty business days after the date of the NMSN.
- (4) Employers must withhold any obligation of the employee for employee contributions necessary for coverage of the child(ren) and send any amount withheld directly to the plan.
- (5) Employees may contest the withholding based on a mistake of fact. If the employee contests such withholding, the employer must initiate withholding until such time as the employer receives notice that the contest is resolved.
- (6) Employers must notify the State agency promptly whenever the noncustodial parent's employment is terminated in the same manner as required for income withholding cases in accordance with Sec. 303.100(e) (1)(x) of this part.
- (7) The State agency must promptly notify the employer when there is no longer a current order for medical support in effect for which the IV-D agency is responsible.
- (8) The State agency, in consultation with the custodial parent, must promptly select from available plan options when the plan administrator reports that there is more than one option available under the plan.

(d) Effective date. This section is effective October 1, 2001, or, if later, the effective date of State laws described in paragraph (a) of this section. Such State laws must be effective no later than the close of the first day of the first calendar quarter that begins after the close of the first regular session of the State legislature that begins after October 1, 2001. For States with 2-year legislative sessions, each year of such session would be regarded as a separate regular session.



U.S. Department of Labor
Employee Benefits Security Administration
2020