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GOVERNOR

STATE OF NEW YORK
DEPARTMENT OF CIVIL SERVICE
THE STATE CAMPUS
ALBANY, NEW YORK 12239
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GEORGE C. SINNOTT
COMMISSIONER

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DEPUTY COMMISSIONER

NY 2004 - 02
PE 2004 - 03
PA 2004 - 05

TO: Agency Health Benefits Administrators

FROM: Employee Benefits Division

SUBJECT: NATIONAL MEDICAL SUPPORT NOTICE GUIDELINES

DATE: March 26, 2004

This memo will provide you with guidance on the processing of National Medical Support Orders (NMSO) which mandate health insurance coverage for certain children. State and local child welfare agencies began using this form as a result of federal legislation (P.L. 105-200). The NMSO was designed to bring uniformity to the administration of the child medical support orders for both the state social welfare agencies and the employers who receive them. While the requirements of the NMSO are explained in the Employer Response and Administrator Response instructions, this memo contains additional guidance specific to the New York State Health Insurance Program (NYSHIP) to assist you in complying with the NMSO requirements. It is not a substitute for reading the NMSO instructions themselves. A sample NMSO is attached to this memo.

Definitions

Participant: Agency employee and/or NYSHIP enrollee

Employer: Employee's Agency (For NYS agencies the State Comptroller (OSC) is usually listed as the employer on the NMSO but for response activities, the employer is the employee's agency, so OSC forwards the NMSO to you)

Plan Administrator: Employee's Agency

Issuing Agency: The court or Social Services Agency that sends the NMSO to the Employer.

Overview

The Issuing Agency sends the NMSO to the Employer. The order indicates which benefits the child(ren) are required to be enrolled in – usually all available benefits are required: Medical, Dental Vision, Mental Health and Prescription drug. The employee's agency is responsible for enrolling the dependent(s) and/or notifying various stakeholders as described below.

Employer Responsibilities

First determine if the individual identified on the NMSO (participant) is currently your agency's employee and then if they are in a benefits eligible position. If the answer to either of these questions is no, complete the applicable section (2 or 3) of Part A of the NMSO, Employer Response, add your contact information to the bottom of the form and send it to the Issuing Agency.

According to NYS law, if health insurance deductions would preclude deductions for full cash child support obligations, the NMSO is not qualified. In this case, check box 4 of Part A of the NMSO, Employer Response, add your contact information to the bottom of the form and send it to the Issuing Agency. If the enrollee has **questions regarding withholding limits or prioritization, they should be referred to the Issuing Agency.**

If the participant is a current employee of your agency in a benefits eligible position and has wages sufficient to cover the health insurance deduction after cash child support obligations, you do not have to complete the Employer Response and should complete the Administrator Response (Part B of the NMSO).

Administrator Responsibilities

① Record the date you received the NMSO on Part B, Plan Administrator Response, and **determine if the NMSO is qualified.** The NMSO is qualified if:

1) The participant's name and address are identified or are reasonable accessible; and
2) The child(ren)'s name and address(es) or the address of the substituted official or agency are identified or are reasonable accessible; and
3) The child(ren) can be covered under NYSHIP*

** The NMSO does not require NYSHIP to provide any benefits to the subject child(ren) which would not be granted to similarly situated dependents. (e.g. dependents over age 19 who are not full time students or disabled under plan definitions are not eligible)*

If the NMSO is not qualified, fill out the appropriate section (5) on the Administrator Response and send the NMSO to the Issuing Agency within 40 business days from the date of receipt. If a child is 19 and older (21 and older for Empire Plan subscribers in some negotiating units) indicate in the space provided in section (5) that coverage until age 25 is available upon proof that the child is a full-time student at an accredited secondary school or college.

If the NMSO is qualified, record the date you determined this in section (1) on the Administrator Response and determine the appropriate NYSHIP coverage for the child(ren).

② **Determination of appropriate NYSHIP coverage** for the child(ren) will vary based on the enrollee's NYSHIP enrollment circumstances (see below chart). In each case however, the child(ren) should be enrolled with the custodial parent's address, substitute official's address or the substitute agency's address, as indicated on the NMSO. In addition, a health insurance identification card must be issued for the dependent to ensure the dependent can access benefits. Empire ID cards will automatically be sent to newly enrolled Empire Plan dependents. A duplicate card should be requested for currently enrolled Empire Plan dependents. Dependents enrolled in NYSHIP HMOs will get a health insurance identification card and benefit information through one of the notification letters described below.

Important address and ID card info

NYSHIP Enrollment circumstance	Appropriate NMSO action
Enrollee and dependent(s) currently enrolled	Check the boxes in section 2 a. Fill in the effective date and plan name.
Enrollee has family coverage, child(ren) is/are not enrolled	Check the boxes in section 2 c. Enroll the child(ren) effective the first day of the pay period following receipt of the NMSO with a DEP/ADD transaction. Fill in the effective date and plan name.
Enrollee has individual coverage	Check the boxes in section 2 d. Change the coverage to family coverage and enroll the child(ren) effective the first day of the pay period following receipt of the NMSO with a CCO/DEP transaction. Fill in the effective date and plan name.
Enrollee is eligible but not enrolled	Call the Issuing Agency contact if a number is provided on the NMSO and explain eligible benefit plans. If there is no contact number available, Check box 3, list the Empire Plan as the default plan and forward a Choices guide and rate sheet to the Issuing Agency*
Employee has not satisfied the new enrollee waiting period	Check the box in section 4. Indicate that coverage may be available after the waiting period is satisfied.

* The NMSO requires the Issuing Agency to choose the plan when an eligible participant has more than one option available. In most cases, the Issuing Agency will not reply within 20 days of mailing the Choices guide and rate sheet and you will enroll the employee and child(ren) in the default - Empire Plan family coverage. It has been our experience that if you call the Issuing Agency, and speak to the case worker for the subject of the order and explain that the Empire Plan is both the most popular plan and the only plan that offers nation-wide coverage, then they will invariably choose the Empire Plan. Calling may save you the steps of sending out the choices guide and waiting for Issuing Agency's response.

Note to Participating Agencies: When an Enrollee is eligible but not enrolled, contacting the Issuing Agency is not necessary if your agency only offers the Empire Plan to employees. Check the box in section 2 and enroll the employee and child(ren) in the Empire Plan effective the first day of the pay period following receipt of the NMSO. Fill in the effective date and plan name.

After you have determined the appropriate NYSHIP coverage based on the above chart, fill in your contact information on the bottom of the Administrator Response and notify the stakeholders as described below.

③ Notification Requirements

Boxed areas on the sample letters are included to assist you and should not be included in final notification letters you develop at your agency.

NYBEAS

The NMSO requires that coverage for the dependent under the order can not be cancelled arbitrarily, even at the enrollee's request. A NYBEAS comment should be added reflecting the dependent name, person#, effective date of coverage and that dependent coverage can not be cancelled unless the enrollee or dependent loses eligibility under plan rules, the dependent receives equivalent coverage under another plan or the court order ceases.

Enrollee

See the attached Enrollee Notification Letter sample for assistance in developing your enrollee responses. If enrollees have questions regarding the NMSO refer them to the Issuing Agency.

Custodial Parent

See the attached notification letters to the Custodial Parent for assistance in developing your responses. There is one sample letter confirming the child was previously enrolled and another confirming the child has recently been enrolled in compliance with the NMSO. In either case, copies of the General Information Booklet and Empire Plan Certificate, Empire Plan update reports and HIPAA policy information should be enclosed for Empire Plan dependents. The General Information Booklet for NYHSIP approved Health Maintenance Organizations, HMO update reports and HIPAA policy information should be enclosed for HMO dependents.

Health Insurance Carriers

See the attached Carrier notification letters for assistance in developing your responses. Empire Plan carriers are told that we have updated our enrollment file in compliance with the NMSO and to process claims for the unemancipated dependents. HMOs are similarly notified but additionally asked to provide health insurance identification cards and benefit information to the dependents.

Issuing Agency

See the attached Issuing Agency notification letters for assistance in developing your responses. One sample is a simple cover letter to the NMSO supplied as proof of compliance with the order.

Note to NYS Agencies: Another sample letter is used to notify the Issuing Agency that a Union Benefit Fund should be contacted as the Plan Administrator for dental and/or vision benefits. This would apply to employees represented by the Civil Service Employee Association, United University Professions or District Council 37.

The Issuing Agency should also be notified if the participant terminates the employment relationship with your agency.

Questions concerning the processing of the NMSO may be forwarded to your agency processor.

SCHENECTADY COUNTY CSEU
MEDICAL SUPPORT UNIT
PO BOX 15369
ALBANY NY 12212-5369

Date: March 7, 2004

IMMEDIATE ACTION REQUIRED

**********AUTO** 3-DIGIT 120
NEW YORK STATE DMV
ATTN PAYROLL GARNISHMENTS
6 SWAN STREET
ALBANY NY 12228

CSMS Case ID:
Worker Code:
RE No:
Employee Name:
Employee SSN:

PLEASE CAREFULLY READ ALL DOCUMENTS

This package contains 2 forms:

1) National Medical Support Notice / Medical Support Execution for Support Enforcement ("Notice"); and
2) Plan Administrator Response Addendum.

The National Medical Support Notice has 2 parts:

- Part A – Notice to Withhold for Health Care Coverage
  - Employer Response
  - Instructions to Employer; and

- Part B – Medical Support Notice to Plan Administrator
  - Plan Administrator Response
  - Instructions to Plan Administrator

Employers are required to:

Review Part A of the Notice and if dependent health care coverage **is not available** to the employee named in the Notice or the employee is no longer working for the employer, the employer must complete Part A of the Notice and return it to the Issuing Agency at the address provided below. Do not complete Part B.

OR

If dependent health care coverage **is available** to the employee, do not complete Part A, forward Part B of the Notice and the Plan Administrator Response Addendum to your health care plan administrator.

Plan Administrators are then required to:

Review and complete Part B of the Notice and the Plan Administrator Response Addendum and return both to the Issuing Agency at the address provided below:

SCHENECTADY COUNTY CSEU
Medical Support Unit
PO Box 15369
Albany NY 12212-5369

Employer

MDXEMP - 745

NATIONAL MEDICAL SUPPORT NOTICE

(Medical Support Execution for Support Enforcement – NYS Civil Practice Law and Rules § 5241)

PART A
NOTICE TO WITHHOLD FOR HEALTH CARE COVERAGE

This Notice is issued under section 466(a)(19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974 (ERISA), and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998.

Issuing Agency: SCHENECTADY COUNTY CSEU Medical Support Unit PO Box 15369 Albany NY 12212-5369 **Date of Notice:** 03/07/2004 **Case Number:** **Telephone Number:** 1-866-431-3096 (option 3) **Fax Number:** (518) 869-7195	**Court or Administrative Authority:** FAMILY COURT-STATE NEW YORK SCHENECTADY COUNTY 620 STATE ST 5TH FL COUNTY OFF BLD SCHENECTADY NY 12307 **Date of Support Order:** 12/11/2003 **Support Order/Docket #:** **Worker Code:** 0008 **Employer Number:** 01

Employer / Withholder's Federal EIN Number

Employer / Withholder's Name
NEW YORK STATE DMV

Employer / Withholder's Address
ATTN PAYROLL GARNISHMENTS
6 SWAN STREET
ALBANY NY 12228

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

Custodial Parent's Mailing Address

Employee's Name (Last, First, MI)

Employee's Social Security Number

Employee's Mailing Address

Substituted Official/Agency Name and Address

Child(ren)'s Mailing Address (if different from Custodial Parent's) or; Name, Mailing Address and Telephone Number of a Representative of the Child(ren)

Child(ren)'s Name(s)	Date of Birth	Social Security Number	Record No.

The order requires the child(ren) to be enrolled in [x] Any health coverages available; or [ ] Only the following coverage(s): ___ Medical; ___ Dental; ___ Vision; ___ Prescription Drug; ___ Mental Health; ___ Other (specify):_____

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 the Issuing Agency on Notice to Withhold for Health Care Coverage): _____

CSMS Case ID:	County Code:	JRE No:	Worker Code:

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** and **Plan Administrator Response Addendum** 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 (***see 1. below***) ____% 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 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: **if the employee's principal place of employment is New York State, deductions to satisfy cash child support obligations, including any additional deductions to satisfy past due cash child support obligation(s), shall have priority over deductions for the employee's share of health insurance premiums (NYS CPLR section 5241 (h)).**

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 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.

Pursuant to New York State law, failure of the employer, organization or group health plan administrator to enroll the eligible dependent(s) in any plan, option or coverage as the notice directs, or failure to deduct from the employee's income the employee's share of the premium or cost therefore, shall make the employer, organization or group health plan administrator jointly and severally liable for all medical expenses incurred on behalf of the employee's dependents named in this Notice while such dependents are not so enrolled to the extent of the health insurance benefits or coverage's that should have been provided pursuant to this notice. (NYS CPLR section 5241 (g)(4)).

Nothing contained in this notice shall require a plan to provide any type 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 Title 42 U.S.C. section 1396(g)(1). The employer, organization or group health plan administrator shall not be required to purchase or otherwise acquire health insurance benefits for such dependents that would not otherwise be available to the employee by reason of employment or membership. (See NYS CPLR 5241(c)(2)(xi) and 5241(c)(2)(vi)).

NOTICE OF TERMINATION OF EMPLOYMENT

In any case in which the above employee's employment terminates the employer must promptly notify the Issuing Agency 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 of 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 (Part A Page 1 of 5) of 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 **Part A – Notice to Withhold for Health Care Coverage** (Part A Page 1 of 5) of this Notice.

MDXEMP - 751

NATIONAL MEDICAL SUPPORT NOTICE

(Medical Support Execution for Support Enforcement – NYS Civil Practice Law and Rules § 5241)

PART B
MEDICAL SUPPORT NOTICE TO PLAN ADMINISTRATOR

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

Issuing Agency: SCHENECTADY COUNTY CSEU Medical Support Unit PO Box 15369 Albany NY 12212-5369 **Date of Notice:** 03/07/2004 **Case Number:** **Telephone Number:** 1-866-431-3096 (option 3) **Fax Number:** (518) 869-7195	**Court or Administrative Authority:** FAMILY COURT-STATE NEW YORK SCHENECTADY COUNTY 620 STATE ST 5TH FL COUNTY OFC BLD SCHENECTADY NY 12307 **Date of Support Order:** **Support Order/Docket #:** **Worker Code:** **Employer Number:**

Employer / Withholder's Federal EIN Number

Employer / Withholder's Name
NEW YORK STATE DMV

Employer / Withholder's Address
ATTN PAYROLL GARNISHMENTS
6 SWAN STREET
ALBANY NY 12228

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

Custodial Parent's Mailing Address

Employee's Name (Last, First, MI)

Employee's Social Security Number

Employee's Mailing Address

Substituted Official/Agency Name and Address

Child(ren)'s Mailing Address (if different from Custodial Parent's) or; Name, Mailing Address and Telephone Number of a Representative of the Child(ren)

Child(ren)'s Name(s)	Date of Birth	Social Security Number	Record No.

The order requires the child(ren) to be enrolled in [x] Any health coverages available; or [ ] Only the following coverage(s): ___ Medical; ___ Dental; ___ Vision; ___ Prescription Drug; ___ Mental Health; ___ Other (specify):_____

PLAN ADMINISTRATOR RESPONSE

To be completed and returned to the Issuing Agency within 40 business days after the date of the Notice, or sooner if reasonable with the **Plan Administrator Response Addendum**.

This Notice was received by the plan administrator on: _____.

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

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

- ☐ a. The child(ren) is/are currently enrolled in the plan as a dependent of the participant.
- ☐ b. There is only one type of coverage provided under the plan. The child(ren) is/are included as dependents of the participant under the plan.
- ☐ c. The participant is enrolled in an option that is providing dependent coverage and the child(ren) will be enrolled in the same option.
- ☐ d. The participant is enrolled in an option that permits dependent coverage that has not been elected; dependent coverage will be provided.

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

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

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

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

- ☐ The name of the ☐ child(ren) or ☐ participant is unavailable.
- ☐ The mailing address of the ☐ child(ren) (or a substituted official) or ☐ participant is unavailable.
- ☐ The following child(ren) is/are at or above the age at which dependents are no longer eligible for coverage under the plan _____ (insert name(s) of child(ren)).

Plan Administrator or Representative:

Name: _____ Telephone Number: _____
Title: _____ Date: _____
Address: _____
No. Street or PO Box

_____
City State Zip

CSMS Case ID:	County Code:	JRE No	Worker Code

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 non-custodial parent/participant identified is enrolled or is eligible for enrollment

This Notice serves to inform you that the non-custodial parent/participant is obligated by an order issued by the court or agency identified in this Notice 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 in this Notice, 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 Plan Administrator Response Addendum**; and send them to the Issuing Agency:

(a) if you checked response 2:

(i) notify the non-custodial parent/participant named herein, 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 non-custodial 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 on **Part B - Medical Support Notice to Plan Administrator** (Part B Page 1 of 4) of this Notice.

MDXEMP - 755

SCHENECTADY COUNTY CSEU
MEDICAL SUPPORT UNIT
PO BOX 15369
ALBANY NY 12212-5369

Date: March 7, 2004

PLAN ADMINISTRATOR RESPONSE ADDENDUM

CSMS Case ID:
Worker Code:
Employee Name:
Employee SSN:

Dear Plan Administrator:

Please complete this form to provide specific information to verify the enrollment of employee children covered under the group plan. Return this completed form along with PART B – MEDICAL SUPPORT NOTICE TO PLAN ADMINISTRATOR to:

SCHENECTADY COUNTY CSEU
Medical Support Unit
PO Box 15369
Albany NY 12212-5369

EMPLOYEE INFORMATION:
Name:
SSN:
Address:

EMPLOYER INFORMATION:
Name: NEW YORK STATE DMV
EIN:
Address: ATTN PAYROLL GARNISHMENTS
6 SWAN STREET
ALBANY NY 12228

1. The participant is subject to a waiting period that expires* ____/____/____ (more than 90 days from the date of receipt of the Notice), or has completed a waiting period 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 end of the waiting period, the plan administrator must process the enrollment.

2. Indicate by **placing a √ in the "yes" or "no" box** if the employee's dependent(s) listed is enrolled under the group health care coverage plan.

Child(ren's) Name	Date of Birth	Social Security Number	Record No.	YES	NO
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

3. Using the list on the reverse side of this form, enter the code for the type of coverage provided under each plan in the boxes. (e.g. MM = Major Medical). Please also enter the name(s) and claims address for each group plan carrier in which the employee dependent(s) listed above is/are now enrolled.

TYPE OF COVERAGE

Code(s)

Group Ins. Carrier #1: _____ NYS INS CD _____

Claims address: _____

_____

Policyholder ID No. _____ Group No. _____ Effective Date: / /

Code(s)

Group Ins. Carrier #2: _____ NYS INS CD _____

Claims address: _____

_____

Policyholder ID No. _____ Group No. _____ Effective Date: / /

Code(s)

Group Ins. Carrier #3: _____ NYS INS CD _____

Claims address: _____

_____

Policyholder ID No. _____ Group No. _____ Effective Date: / /

Code(s)

Group Ins. Carrier #4: _____ NYS INS CD _____

Claims address: _____

_____

Policyholder ID No. _____ Group No. _____ Effective Date: / /

Code(s)

Group Ins. Carrier #5: _____ NYS INS CD _____

Claims address: _____

_____

Policyholder ID No. _____ Group No. _____ Effective Date: / /

COVERAGE CODES					
CL	Clinic	ER	Emergency Room	PO	Physician in-office
CM	Complement to Medicare	HH	Home Health	PI	Psychiatric in-patient
DN	Dental	IP	In-Patient	PS	Psychiatric out-patient
DM	Drugs (Major Medical)	MM	Major Medical	SI	Substance abuse in-patient
DR	Drugs (no card provided)	NH	Nursing Home	SO	Substance abuse out-patient
DC	Drugs (with co-pay)	OP	Optical	TR	Transportation
EQ	Durable medical equipment	PH	Physician in-hospital		

Completed By: _____ Title: _____

Phone Number: _____ Date: _____

CSMS Case ID: County Code JRE No Worker Code

Health Insurance Premium Withholding Limitations Worksheet

Use this form with the "National Medical Support Notice"

Before you begin:

- ✓ Calculate employee's disposable earnings (use worksheet on reverse if necessary).
- ✓ Be sure to include in your calculation all earnings paid or payable to employee (see definition on reverse).
- ✓ Determine if you are withholding child support from earnings based on an income execution and, if so, how much you are withholding.
- ✓ Determine if employee is supporting a spouse or dependent child other than those covered by this matter.

---

1. Enter the employee's disposable earnings for one pay period. 1. _____

2. Enter the amount (if any) being withheld for child support for one pay period. * 2. _____*

3. Enter the amount to be withheld for the health insurance premium for one pay period. 3. _____

4. Add lines 2 and 3. 4. _____

5. Divide line 4 by line 1. (Enter the result as a percentage) 5. _____%

6. Does line 5 exceed the CCPA limitations? (See CCPA limitations chart on reverse)

☐ Yes. DO NOT withhold the health insurance premium. Since the combined amount for child support and the health insurance premium exceeds CCPA limitations, withholding for health insurance premiums based on the National Medical Support Notice is not permitted. Check Box 4 of Part A of the Employer Response (page 2 of 5) of the Notice and return the form.

☐ No. Withhold the health insurance premium amount entered on line 3 each pay period.

* Upon any future change in this amount, you must recalculate the limitations on withholding for health insurance premiums by re-doing this worksheet.

Disposable Earnings Worksheet

- "Earnings" means compensation paid or payable for personal services, such as wages, salary, commission, or bonus, and includes periodic payments pursuant to a pension or retirement program.
- "Disposable Earnings" means that part of the earnings remaining after deduction of any amounts required by law to be deducted.

The following worksheet may be used to calculate disposable earnings:

1. Gross earnings. 1. _____

2. Amounts deducted as required by law:

a.	Federal income tax	a. _____
b.	Social security tax	b. _____
c.	Medicare tax	c. _____
d.	State income tax	d. _____
e.	City/local income tax	e. _____
f.	Involuntary retirement or pension plan payments	f. _____

Add lines 2 a-f. These are the total deductions required by law. 2. _____

3. Subtract line 2 from line 1. This is the employee's disposable earnings. 3. _____

Consumer Credit Protection Act
Limitations on Withholdings for Support
15 U.S.C. 1673 (b)

The following federal limitations apply to the withholding from disposable earnings for the satisfaction of health insurance premiums and/or child support payments:

MAXIMUM WITHHOLDING FROM DISPOSABLE EARNINGS

	No arrears, or arrears less than 12 weeks old*	Arrears owed for at least 12 weeks*
Employee supports spouse or child other than those covered by this matter.	50%	55%
Employee is not supporting a spouse or child other than those covered by this matter.	60%	65%

* see page 1 of Notice

Empire Carrier Notification

Date

Empire Carrier Name
Empire Carrier Street Address
Empire Carrier City/State/Zip

RE: (Enrollee Name)
SS # (Enrollee SS#)

Dear Empire Carrier Name:

Enclosed is a copy of a National Medical Support Notice (Notice) for (Enrollee's Name). Please process claims for the dependent(s) in accordance with the terms of the Notice.

Thank you for your cooperation.

Sincerely,

HBA Name
HBA Title

Enclosure

Note: Each Empire Plan Carrier must be sent a copy of the National Medical Support Notice. The carrier addresses may be found in the General Information Booklet.

Health Maintenance Organization Notification

Date

HMO Name
HMO Street Address
HMO City/State/Zip

RE: (Enrollee Name)
SS # (Enrollee SS#)

Dear HMO Name:

Enclosed is a copy of a National Medical Support Notice (Notice) for (Enrollee's Name). Please update your records and process claims for the dependent(s) in accordance with the terms of the Notice. In addition, please send cards and any necessary benefit information to the appropriate address (custodial parent address or substitute official address) on the Notice.

Thank you for your cooperation.

Sincerely,

HBA Name
HBA Title

Enclosure

Note: The HMO addresses may be found in the *Choices* guide

Issuing Agency Notification

Date

Issuing Agency Name
Issuing Agency Street Address
Issuing Agency City/State/Zip

RE: (Case #)

To Whom It May Concern:

Enclosed is the Plan Administrator Response to the National Medical Support Notice for (Enrollee's name), SS# (Enrollee's SS#).

Sincerely,

HBA Name
HBA Title

Enclosure

Issuing Agency - EBF Notification

Date

Issuing Agency Name
Issuing Agency Street Address
Issuing Agency City/State/Zip

RE: (Case #)

To Whom It May Concern:

Enclosed is the Plan Administrator Response to the National Medical Support Notice for (Enrollee's name), SS# (Enrollee's SS#).

Please be advised that the enrollee has health insurance through the New York State Health Insurance Program (NYSHIP). However, the dental and vision coverage is provided through the (Union Benefit Fund Name). You may contact them at (Union Benefit Fund telephone number) or by writing to:

(Union Name) Benefit Fund
(Street Address)
(City/State/Zip)

Sincerely,

HBA Name
HBA Title

Enclosure

Union Benefit Fund Contact Information

CSEA Employee Benefit Fund
1 Lear Jet Lane Suite 1
Latham, NY 12110-2395
800 323-2732

United University Professions
Benefit Trust Fund
800 Troy-Schenectady Road
Latham, NY 12110-2455
800-887-3863

District Council 37
AFSCME, AFL-CIO
125 Barclay Street
New York, NY 10007
(212) 815-1000

Custodial Parent Notification

Adding dependent(s)

Date

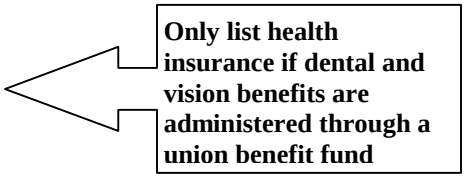
Custodial Parent Name
Custodial Parent Street Address
Custodial Parent City/State/Zip

RE: (Case #)

Dear Custodial Parent Name:

This concerns the National Medical Support Notice for [name of dependent(s)]. Pursuant to the notice, we are confirming enrollment as a dependent of [enrollee's name] effective [date of coverage] in the following plans in the New York State Health Insurance Program:

Health Insurance	Empire Plan or HMO
Dental Coverage	GHI Dental Plan
Vision Coverage	Davis Vision



Please be advised, we have updated the dependent's address(es) as above. We have requested new health insurance card(s) to go to the above address. In addition, we have enclosed useful materials describing plan benefits and eligibility rules for Empire Plan dependents or have requested similar materials be sent to you from an HMO if applicable. Enrollment questions should be directed to our office at [HBA telephone].

Sincerely,

HBA Name
HBA Title

Enclosure

Note: Enclosures include: a copy of the NMSO, and a General Information Booklet and addendums for the Empire Plan or HMOs as applicable.

Custodial Parent Notification

Confirming dependent(s) currently enrolled

Date

Custodial Parent Name
Custodial Parent Street Address
Custodial Parent City/State/Zip

RE: (Case #)

Dear Custodial Parent Name:

This concerns the National Medical Support Notice for [name of dependent(s)]. Pursuant to the notice, we are confirming that the above noted child(ren) are already enrolled as [a] dependent[s] of [enrollee's name] in the following plans in the New York State Health Insurance Program:

Health Insurance	Empire Plan or HMO
Dental Coverage	GHI Dental Plan
Vision Coverage	Davis Vision

Only list health insurance if dental and vision benefits are administered through a union benefit fund

Please be advised, we have updated the dependent's address(es) as above. We have requested new health insurance card(s) to go to the above address. In addition, we have enclosed useful materials describing plan benefits and eligibility rules for Empire Plan dependents or have requested similar materials be sent to you from an HMO if applicable. Enrollment questions should be directed to our office at [HBA telephone].

Sincerely,

HBA Name
HBA Title

Enclosure

Note: Enclosures include: a copy of the NMSO, and a General Information Booklet and addendums for the Empire Plan or HMOs as applicable.

Enrollee Notification

Date

Enrollee Name
Enrollee Street Address
Enrollee City/State/Zip

RE: (Case #)

Dear Enrollee Name:

This concerns the National Medical Support Notice for [name of dependent(s)]. Pursuant to the notice, we are confirming enrollment as your dependent effective [date of coverage] in the following plans in the New York State Health Insurance Program:

Health Insurance	Empire Plan or HMO
Dental Coverage	GHI Dental Plan
Vision Coverage	Davis Vision

Only list health insurance if dental and vision benefits are administered through a union benefit fund

Please be advised, we have updated the dependent's address(es) to reflect that of the custodial parent. Any question regarding this issue may be directed to our office at [HBA telephone].

Sincerely,

HBA Name
HBA Title

Enclosure

Note: Enclosure a copy of the NMSO. The second sentence applies to an enrollee that currently has individual coverage. You will have to modify this sentence to cover enrollees with various enrollment situations such as those with existing family coverage or enrollees that are not currently enrolled in any health insurance plan.