CHIP Coverage Coordination Disclosure Form Instructions

I. Introduction.

The CHIP Coverage Coordination Disclosure Form is a form that is sent by a state to a plan administrator of a group health plan. The plan administrator completes the Form and returns it along with all required attachments to the issuing state. The purpose of the Form is for the state to determine the availability and cost-effectiveness of coverage available under the group health plan to employees who have family members who are eligible for premium assistance offered under a state plan under Titles XIX or XXI of the Social Security Act and to allow coordination of coverage for enrollees of such plans.

As set forth on Page 1 of the Form, under Section 502(c)(9)(B) of the Employee Retirement Income Security Act (ERISA) (29 U.S.C. §1001 et seq.), the plan administrator may be fined up to $100 per day from the date of the plan administrator's failure to timely provide this completed Form (and all required attachments) to the state. Each violation with respect to a single individual is treated as a separate violation for purposes of this penalty.

States may decide to add additional disclosures and/or questions to this Form. However, the penalty set forth above shall not apply to any items added by a State. Alternatively, a State may choose to remove disclosures and/or questions from this Form without affecting the application of the penalty to the remaining items.

II. When and How to Respond.

The plan administrator must send the completed Form and all accompanying attachments to the issuing state no later than 30 days after the date set forth in Part I(A) of the Form. The Form and all requested attachments must be sent via US Postal Service First Class Mail or other private delivery service. [State may insert alternate or optional submission instructions via electronic mail or website.]

III. Accompanying Information.

If more space is needed or if you are required to attach additional information with respect to an item, the additional pages must be the same size as this Form (8 ½ x 11) and must include the name of the group health plan, the part, section and line number and the word "Attachment" in the upper right corner. In addition, the attachment for any item should be in a format similar to that item on the Form.

IV. Definitions.

Employee

The individual who is the subject of the request from the state and who is listed in Part I – Section B.

Employer / Plan Sponsor

The entity that sponsors the group health plan, including a plan established and maintained by a single employer, as well as a plan established and maintained by two or more employers or jointly by one or more employers and one or more employee organizations. This includes a "multiemployer plan" as defined in ERISA Section 3(37)(A).

Group Health Plan

See, ERISA Section 733(a)(1). There are certain benefits that are offered by a group health plan that are excepted benefits under Part 7 of ERISA and for which this Form does not apply, including limited-scope dental or vision benefits, as described in ERISA Section 733(c)(2).

Plan Administrator

See, ERISA Section 3(16)(A), defining administrator as a person specifically designated by the terms of the plan, or if no such person is designated, the plan sponsor.

State

See, ERISA Section 3(10), defining State as including any State of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, and the Canal Zone. For purposes of this Form, this term includes any instrumentality or agency thereof.

V. Line-By-Line Explanation.

Part I

To be completed by the state prior to sending the Form to the plan administrator.

For the date, insert the date that the Form is sent to the plan administrator.

Part II – Section A

To be completed by the plan administrator. Any penalty for a failure to properly or timely complete this Form will be imposed on the plan administrator, as noted in Section I of these Instructions.

Section A(1)(ii): If you complete this box, skip to Section D, complete the information required and then return the Form to the issuing state.

Section A(2)(ii): If the employee is eligible but has not yet satisfied a waiting period, complete the required information. For this purpose, waiting period means the period of time that must pass before coverage can become effective for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan.

Section A(2)(iii): If you complete this box, you must also check a reason box plus complete the required information (if the "other" box is checked). After completing the appropriate information, skip to Section D, complete the information required and then return the Form to the issuing state.

Section A(3)(i): If the employee has already enrolled complete the required information. If the employee has enrolled, but his/her enrollment is not yet effective (e.g., due to a waiting period), complete the required information and indicate on the effective date line the future date on which coverage will be effective. For example, if the employee enrolled on March 15, but his/her coverage is not effective until the first of the next month, complete the requested information and put April 1 in the effective date line. If the employee is enrolled, but has not enrolled his/her spouse/children/other dependents, write "no dependents are enrolled" in the line asking for enrolled dependent names.

Part II – Section B

If you completed Section A(3)(i), only complete Section B with respect to the coverage option in which the employee is enrolled.

If you completed Section A(3)(ii), complete Section B with respect to each coverage option in which the employee is eligible to enroll.

If the plan has more than three options for which the employee is eligible to enroll, you must either complete the chart in Section B for the first 3 options and attach a separate document for the remaining options that includes all of the information requested in the chart, or attach a separate document for all of the options that includes all of the information requested in the chart. You must also check the box in Section B that an attachment is included.

The only coverage options that are covered by this Form are those that are offered under the group health plan and that are not excepted benefits under Part 7 of ERISA. For example, a stand-alone dental and vision benefit that qualifies as an excepted benefit under ERISA Section 733(c) is not required to be listed as a separate coverage option. See the regulations at 29 CFR 2590.732(c) for more information on excepted benefits.

Line 1: Insert the name of the insurer or third party administrator that processes claims for the coverage option.

Line 2: Insert the name for which the plan refers to the coverage option, such as basic, enhanced, preferred provider organization (PPO), etc.

Line 3: Insert the name of the group health plan and plan number used for ERISA purposes.

Line 4: Check all boxes that apply. Checking a box merely provides that coverage for the listed benefit is provided by the option regardless of whether any applicable co-insurance, co-pay or deductible may apply.

Line 5: Even though a separate, stand-alone dental benefit is not required to be listed as a separate option in the chart, check the appropriate box regarding whether and how dental benefits are offered by the plan.

Line 6: You must attach a summary plan description (SPD) and all applicable summaries of material modifications (SMM) for each coverage option (or other similar summaries of plan terms provided by an entity not subject to ERISA). If you also distribute a separate insurance certificate for any insured options, you must also attach the insurance certificate. If you do not check the applicable boxes on Line 6 and attach the applicable documents the Form will be incomplete.

Line 7: If a coverage option will change for the following plan year, include the last date through which benefits will remain unchanged (for example, December 31st).

Line 8: If certain benefits offered by an option will change for the following plan year, such as deductibles, co-insurance percentages, etc., you must attach the following plan year's enrollment guide or other enrollment documentation that includes these changes, if available. This requirement only applies if benefits offered by the option will change and those changes have been communicated to employees and/or participants. For example, if you receive the Form in December, benefits will change as of the following January 1 and employees have already enrolled for the following plan year's options, you must include any enrollment documentation describing the changes.

Part II – Section C

The same background instructions for Part II – Section B apply to Part II – Section C.

Lines 1 and 2: Insert the same information for Lines 1 and 2 of Section B.

Line 3: If you have a separate rate sheet or other document that you distribute to employees indicating the monthly premiums for employees, check the appropriate box and attach the rate sheet or other document to this Form. If such rate sheet or other document does not indicate the employer's share of premiums, you must still complete Line 3 with respect to the employer information (or otherwise include the information on an attachment). Convert all dollar amounts to a monthly amount.

If the employer has any premium surcharge that is in addition to the regular premium listed in the appropriate coverage tier, include such surcharge as a separate premium and list the coverage tiers to which the surcharge applies. Attach any additional information necessary to explain such surcharge. This includes premium surcharges for spouses, children and other dependents, as well as surcharges for wellness programs under 29 CFR 2590.702(f)(2).

Line 4: Indicate the frequency for which the monthly premiums listed in Line 3 are paid.

Line 5: Indicate the premium period for which the premiums are paid. For example, if the employee is paying monthly premiums and the employee pays the premium on the first paycheck of the month, indicate whether such premium is for the prior month, the current month or the following month.

Line 6: Indicate whether the premiums are paid pre-tax through a cafeteria or flexible benefit plan under Internal Revenue Code Section 125.

Part II – Section D

Plan Administrator Name: If the employer is the plan administrator, insert the name of the employer. If a committee or an individual of the employer is the plan administrator, insert the name of the committee or individual.

Representative / Contact Person Name: You must insert the name and contact information of an individual that is familiar with this Form and the information requested by this Form. The issuing state has the authority to contact this person regarding any questions the state may have with respect to the information provided and the attachments.

Attestation: The plan administrator or authorized representative of the plan administrator must sign this form.

Attachments: Various documents are required to be attached to the Form, including a current summary plan description for each option listed in Section B. Make certain you have included all required attachments. Penalties may apply if all required documents are not attached.

CHIP Coverage Coordination Disclosure Form

This Form is issued under Section 311(b)(1)(C) of the Children's Health Insurance Program Reauthorization Act of 2009, Section 701(f)(3)(B)(ii) of the Employee Retirement Income Security Act of 1974 (ERISA), Section 9801(f)(3)(B)(ii) of the Internal Revenue Code of 1986, and Section 2701(f)(3)(B)(ii) of the Public Health Service Act.

The Plan Administrator may be fined under ERISA Section 502(c)(9)(B) for failure to properly complete this Form and return it (along with all required attachments) to the state/issuing agency within 30 days from the date listed in Part I.

Please see the instructions prior to completing this Form.

Part I: To be Completed by the Issuing State

Section A. Issuing State Information.

Date Sent: _____ Case or Identifying Number:_____

Issuing State/Agency: _____

Address: _____

_____

State/Agency Contact Person Name:_____

Phone: _____ Fax:_____

E-Mail: _____

Section B. Employee Information.

Employee Name: _____

Employee Address: _____

_____

Employee SSN Last 4 Digits: _____

Part II: To be Completed by the Plan Administrator

Section A. Group Health Plan Eligibility.

(1) Plan Sponsorship (check (i) or (ii) below).

(i) ☐ The employer/plan sponsor maintains a group health plan providing health coverage for (check all that apply):

☐ Employees
☐ Spouses
☐ Children
☐ Other (describe) _____

(ii) ☐ Employer/plan sponsor does not maintain any group health plan providing health coverage. (If you check this box, skip to Section D.)

(2) Eligibility (Check (i), (ii) or (iii) below).

(i) ☐ The Employee is currently eligible for enrollment in health coverage under a group health plan maintained by the employer / plan sponsor.

(ii) ☐ The Employee is currently eligible for enrollment in health coverage under the employer's / plan sponsor's group health plan but such coverage would not become effective until the completion of a waiting period.

Assuming the Employee continues to work and remains eligible, the waiting period is expected to end on _____.

(iii) ☐ The Employee is not currently eligible for enrollment in health coverage under any group health plan maintained by the employer / plan sponsor because (check all boxes that apply and complete the required information in the blanks directly below):

☐ The Employee is not among an eligible class

☐ The Employee has not yet worked enough hours

☐ The Employee terminated employment on _____

☐ Other (describe requirement and reason Employee is not eligible):
_____
_____

(After completing (iii) above, skip to Section D.)

(3) Enrollment Status (Check (i) and complete required information or check (ii).)

(i) ☐ The Employee is (or will be) enrolled in health coverage under the employer's / plan sponsor's group health plan.

Effective Date: _____
Carrier/Insurer Name: _____
Plan Option Name/Type: _____
Coverage Tier: _____
Enrolled Spouse/Children/Dependent Names: _____
_____
_____

(ii) ☐ The Employee is not enrolled in health coverage under the employer's / plan sponsor's group health plan.

Section B. Benefits Offered Under the Group Health Plan.

If you completed Section A(3)(i) above, only complete Section B with respect to the coverage in which the Employee is enrolled. Alternatively, if you completed Section A(3)(ii) above, complete Section B with respect to each health coverage option in which the Employee is eligible to enroll.

If the employer / plan sponsor has more than three options for which the Employee is eligible to enroll, attach a separate document that includes all of the information requested in the chart below for the additional options and check here ☐.

See also Lines 6 and 8 below, Section D and the instructions regarding various documents that must also be attached for all options.

Certain benefit options are exempt from this Form, including stand-alone dental and vision benefits (see instructions).

	Option #1	**Option #2**	**Option #3**
1. Insurer / Carrier / Claims Administrator Name			
2. Plan Option Name / Type			
3. ERISA Plan Name and Plan Number (if applicable)			
4. General Benefits / Services of Option	☐Inpatient Hospital ☐Outpatient Hospital ☐Physician Surgical ☐Physician Medical ☐Lab and X-ray ☐Well-baby/child ☐Child Immunization ☐Emergency ☐Prescription Drug ☐Mental Health	☐Inpatient Hospital ☐Outpatient Hospital ☐Physician Surgical ☐Physician Medical ☐Lab and X-ray ☐Well-baby/child ☐Child Immunization ☐Emergency ☐Prescription Drug ☐Mental Health	☐Inpatient Hospital ☐Outpatient Hospital ☐Physician Surgical ☐Physician Medical ☐Lab and X-ray ☐Well-baby/child ☐Child Immunization ☐Emergency ☐Prescription Drug ☐Mental Health
5. Dental Benefits	☐Dental benefits included with option and included in option premium ☐Dental benefits offered separately with a separate premium ☐Dental benefits are not offered	☐Dental benefits included with option and included in option premium ☐Dental benefits offered separately with a separate premium ☐Dental benefits are not offered	☐Dental benefits included with option and included in option premium ☐Dental benefits offered separately with a separate premium ☐Dental benefits are not offered
6. Additional Required Documents to be Attached to this Form	☐SPD / SMM ☐Insurance Certificate	☐SPD / SMM ☐Insurance Certificate	☐SPD / SMM ☐Insurance Certificate

	Option #1	Option #2	Option #3
7. Benefits Effective Through Listed Date			
8. Additional Required Documents for Any Option Changes After Date Listed in Line 7	☐Enrollment Guide ☐SMM ☐Other _____	☐Enrollment Guide ☐SMM ☐Other _____	☐Enrollment Guide ☐SMM ☐Other _____

Section C. Premiums Under the Group Health Plan.

If you completed Section A(3)(i) above, only complete Section C with respect to the coverage in which the Employee is enrolled. Alternatively, if you completed Section A(3)(ii) above, complete Section C with respect to each health coverage option in which the Employee is eligible to enroll.

Information required by Line 3 of this Section C can be furnished on a separate document that meets certain requirements (see instructions). If you are furnishing information required by Line 3 below on a separate document, you must attach the separate document and check here ☐.

If the employer / plan sponsor has more than three options for which the Employee is eligible to enroll, you must attach a separate document that includes all of the information requested in the chart below for the additional options and check here ☐.

	Option #1	Option #2	Option #3
1. Insurer/ Carrier / Claims Administrator Name			
2. Plan Option Name / Type			
3. Monthly Premiums			
(a) Single Coverage	Employee $_____ Employer $_____	Employee $_____ Employer $_____	Employee $_____ Employer $_____
(b) Employee + _____	Employee $_____ Employer $_____	Employee $_____ Employer $_____	Employee $_____ Employer $_____
(c) Employee + _____	Employee $_____ Employer $_____	Employee $_____ Employer $_____	Employee $_____ Employer $_____
(d) Employee + _____	Employee $_____ Employer $_____	Employee $_____ Employer $_____	Employee $_____ Employer $_____
4. Frequency of Payroll Deductions	☐Biweekly 24 ☐Biweekly 26 ☐Weekly 48 ☐Weekly 52 ☐Semi-Monthly on _____ and _____ ☐Monthly on _____	☐Biweekly 24 ☐Biweekly 26 ☐Weekly 48 ☐Weekly 52 ☐Semi-Monthly on _____ and _____ ☐Monthly on _____	☐Biweekly 24 ☐Biweekly 26 ☐Weekly 48 ☐Weekly 52 ☐Semi-Monthly on _____ and _____ ☐Monthly on _____

	Option #1	Option #2	Option #3
5. Premium Period to which the Payroll Deductions Apply	☐ Same Period ☐ Prior Period ☐ Next Period	☐ Same Period ☐ Prior Period ☐ Next Period	☐ Same Period ☐ Prior Period ☐ Next Period
6. Premiums paid through a cafeteria plan under IRC Section 125	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section D. Plan Administrator and Contact Information.

Plan Administrator Name: _____

Address: _____

_____

Plan Administrator Representative / Contact Person Name*:

_____

Phone: _____ Fax:_____

E-Mail: _____

* The issuing state/agency may contact this person regarding this Form.

Under penalty of perjury, the plan administrator hereby declares that the plan administrator has examined this Form, including all accompanying attachments, and to the best of the plan administrator's knowledge and belief, it is true, correct and complete in all material respects.

Signature: _____ Date:_____

Print Name: _____ Title: _____

This Form requires a number of attachments, including a copy of each option's summary plan description (SPD) listed in Section B, Line 6. Review the Instructions and make certain you have attached all required documents to this Form.

This Form, including all accompanying attachments, must be returned to the issuing state at the address listed in Part I within 30 days from the date listed in Part I.