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.

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.

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. This 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). Certain benefits are exempt from the definition of a group health plan 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 an eligible individual can enroll in the group health plan or until the eligible individual's enrollment can be effective.

Section A(2)(iii): If you complete this box, you must also check a reason box plus complete the required information. For example, if you check the box indicating that the Employee is not among an eligible class of employees, you must indicate which classes of employees are eligible for group health plan coverage (e.g., salaried only), and indicate which class the employee is within (e.g., hourly). 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.

Section A(4): This question asks whether you anticipate any eligibility and/or enrollment changes for the employee within the next 60 days. For example, anticipated changes include pending promotions,

demotions or employment terminations that would affect eligibility or enrollment of the employee in the group health plan.

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 complete the chart in Section B for the first 3 options, and then attach a separate document for the remaining options that includes all of the information requested in the chart.

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.

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 8: 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 do not check the SPD/SMM box and attach the applicable documents the Form will be incomplete. If you use an insurance certificate as the SPD, also check the appropriate box and attach to this Form. If certain coverage options will change for the following plan year, such as deductibles, co-insurance percentages, etc., you must attach the most current SPD and all SMMs as indicated above, and if available the following plan year's enrollment guide or other enrollment documentation that includes these changes.

Line 9: 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). As noted in Line 8, if available include the following plan year's enrollment guide or other enrollment information that includes these 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. Otherwise complete all required information for all of the coverage tiers available under each coverage option. 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 "other." 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 plan under Internal Revenue Code Section 125.

Line 7: Indicate whether the employer makes available additional flex credits or flex contributions under the cafeteria plan for which an employee can use to further reduce the applicable premium listed in Line 3 above. If so, attach any information that further explains the amount and the use of such flex credits or flex contributions. In general, a flex credit or flex contribution is an additional employer contribution provided to employees under the cafeteria plan, and such flex credit or flex contribution can be used by the employee to pay for one or more qualified benefits under the cafeteria plan.

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.