Qualified Medical Child Support Orders

(QMCSO)

A State court or agency may require the Fund to provide Group Protection Plan coverage to children by issuing a medical support order. The Fund Office must determine whether the medical child support order is "Qualified".

To be considered a "Qualified" order it must contain the name and last known address of the Participant and each alternate recipient (Child) and the period to which the order applies. If the Employee Participant's Eligibility requirements have not been met, the child's eligibility will begin upon the Employee's satisfying the eligibility requirements. This Plan adds newly eligible participants for coverage the first of each month. Coverage to the child will be effective as of the first day of the month following the determination that the order is "Qualified" and all Enrollment Requirements have been met. The child will have the same continuation rights under COBRA as the Covered Employee Participant.

The Plan must comply with the terms of the order. The Plan will pay benefits (in reimbursement for expenses incurred and paid by an alternate recipient or the child's custodial parent or legal guardian) to the alternate recipient, custodial parent, legal guardian, or the provider of health services. In certain cases, payment may be required to be made to a State child support enforcement of Medicaid agency.

If the Fund Office receives a Medical Support Notice or Court order and determines that it is a QMCSO, we will inform the State agency of any outstanding enrollment requirements, and when Coverage under the Plan will begin. The Fund Office will provide the custodial parent or guardian of the child with information about the coverage under the Plan (Summary Plan Description) and any enrollment forms or documents necessary to start eligibility and make claims. The Employee Participant will be copied on this correspondence.

The complete QMCSO Procedures are attached.

If you should have any question about QMCSOs or need additional information, please do not hesitate to contact the Fund Office.

QMCSO PROCEDURES

I. Introduction

This document sets forth the procedures to be followed by the U. A. Plumbers Local Union No. 68 Group Protection Plan upon receipt of “qualified medical child support orders” (QMCSOs), including National Medical Support Notices. These QMCSO procedures have been developed in accordance with Section 609(a) of the Employee Retirement Income Security Act of 1974 (ERISA), which requires group health plans to establish administrative procedures for determining whether orders are QMCSOs and administering the provision of benefits under QMCSOs. They are designed to assist the plan administrator in determining whether a particular order is a QMCSO and in carrying out its responsibilities relating to QMCSOs.

A. QMCSO Defined

A QMCSO is a judgment, decree, or order, issued by a court or through a state administrative process, that requires health plan coverage for the child of a participant (called an “alternate recipient”) and meets certain legal requirements. Such orders typically are issued as part of a divorce or as part of a state child support order proceeding. Federal law requires a group health plan to pay benefits in accordance with such an order, if it is “qualified.” A QMCSO may apply to an employer's major medical plan, as well as to other types of group health plans such as dental plans, vision plans, and health FSAs. In general, a child who is an alternate recipient under a QMCSO is to be treated like any other beneficiary under the plan.

State child support enforcement agencies are required to use the National Medical Support Notice when enforcing the provision of health care coverage to children under an employment-related group health plan. This is a standard form that was jointly developed by the DOL and HHS. When properly completed by the issuing agency, the Notice will constitute a QMCSO. Other orders are not required to follow a standard format.

In some cases, orders will refer to or require a plan to comply with state laws enacted in response to Section 1908A of the Social Security Act, which requires states to enact certain medical child support laws in order to receive federal Medicaid funds. These state laws are designed to help state governments and non-employee parents obtain private-sector health coverage for children, including coverage under employer-sponsored group health plans.

B. Plan's Rights and Responsibilities Relating to QMCSOs

Plans are not required to provide coverage in accordance with child support or other court orders that are not “qualified” in accordance with ERISA §609(a). The plan administrator has the ultimate authority to determine whether an order

meets the requirements of ERISA §609(a). If the order does not meet these requirements, the plan need not provide any benefits to the alternate recipient, unless the child is otherwise eligible or the order's deficiencies are corrected by the parties.

All actions related to QMCSOs must be made in accordance with these procedures and must be performed on a timely basis.

II. Procedures for Determining Whether Orders are QMCSOs

A. Upon Receipt of an Order

The procedures to be followed upon receipt of an order depend on whether the order is a National Medical Support Notice or another type of order.

1. Upon Receipt of a National Medical Support Notice

Upon receipt of a National Medical Support Notice, the plan administrator must:

- promptly provide the participant and the alternate recipient named in the order (and their legal representatives, if any) with written notice of (a) the receipt of the Notice; and (b) the plan's QMCSO procedures; and

- review the Notice to determine if it has been properly completed and meets the legal requirements of a QMCSO, using the Checklist attached to these procedures and the instruction to the employer and the plan administrator on the Notice itself.

Within 40 business days after the date of the Notice, or sooner if reasonable, the plan administrator must notify the participant, alternate recipient, state agency, and any legal representatives or other parties indicated in the Notice, using the spaces indicated on the Notice, that either:

- the Notice is a QMCSO; or

- the Notice is not a QMCSO (the plan administrator's reasons for rejecting the Notice should be indicated in the space provided on the Notice).

This notification generally can be provided by sending copies of the completed “Plan Administrator Response” to the Notice to the parties. In addition, if the Notice is determined to be a QMCSO, the parties must be provided with certain information, such as the effective date of the child's

coverage (or the steps necessary to effectuate coverage), a description of the coverage, and any forms or documents necessary to enroll in the plan. (See the instructions to the Notice.)

2. Upon Receipt of Any Other Order

Upon receipt of an order other than a National Medical Support Notice, the plan administrator must:

- promptly provide the participant and the alternate recipient named in the order (and their legal representatives, if any) with written notice of (a) the receipt of the order; and (b) the plan's QMCSO procedures; and

- review the order to determine if it meets the legal requirements of a QMCSO, using the Checklist attached to these procedures.

Within a reasonable time after receipt of the order (the time limits for reviewing the National Medical Support Notice will be used as a guideline), the plan administrator must notify the participant and alternate recipient that either:

- the order is a QMCSO; or

- the order is not a QMCSO (an explanation of the defective or missing provisions should be included).

Copies of the notification should also be provided to the parties' legal representatives, if any.

B. Designation of Representative

An alternate recipient may designate a representative to receive copies of notices that are sent to him or her with respect to an order.

C. Disputes

Within 30 days after the date of the plan administrator's notice as to whether an order is a QMCSO, the parties (or their legal counsel) will have the right to submit written comments regarding the determination. After considering any comments received, the plan administrator will make a final determination as to the qualified status of the order. If no comments are received during the 30-day period, the decision will become final.

D. Resubmitted Orders

If an order (including a National Medical Support Notice) is determined to not to

be a QMCSO, the parties or agency may submit a revised order to cure the deficiencies. If a revised order is submitted, the evaluation process is repeated.

Article III. Additional Considerations

A. Checklist for Assessing Whether an Order is a QMCSO

The Checklist attached to these procedures includes a list of the provisions that are required for a medical child support order to be considered a QMCSO.

B. Forms and Information

Additional forms and information may be necessary to effectively administer benefits under an order that has been determined to be a QMCSO and to enroll the alternate recipient in the applicable plans. These forms and information include the following:

- The name and address of the alternate recipient's custodial parent, legal guardian, or other person(s) to whom the SPDs and other plan-related information and correspondence should be furnished following the alternate recipient's enrollment. Where an agency is involved (as in the case of a National Medical Support Notice), it may be necessary or appropriate to provide certain plan information and/or correspondence to the agency as well.

- **A completed enrollment form, is required under the plan.**

- The name and address of an individual to whom it is expected that benefit reimbursements may be made for the alternate recipient's child's claimed expenses. The QMCSO rules provide that if medical expenses are paid by either the alternate recipient or the alternate recipient's custodial parent or legal guardian, a plan must reimburse that person (not the employee) for those expenses. If expenses are submitted for reimbursement, information identifying the individual to receive payment should be provided to the plan.

Note that a QMCSO may provide that a person or entity other than the participant is responsible to pay for the alternate recipient's coverage. In such cases, the plan administrator should indicate how and when payment is to be made. The plan administrator should also make sure that it has contact information for the person or entity who will be making the payments.

C. Alternate Recipient as “Beneficiary”

In general, the alternate recipient must be treated like any other beneficiary under each plan in which he or she is enrolled

- Unless a QMCSO is more restrictive, the alternate recipient should be given the same coverage as would be provided to any other dependent child under the plan.

- The alternate recipient should be treated as a qualified beneficiary and offered COBRA continuation coverage upon the occurrence of a COBRA qualifying event (such as the participant's termination of employment or the alternate recipient's ceasing to qualify as a dependent child under the plan due to age or student status).

D. Alternate Recipient as “Participant”

With respect to ERISA reporting and disclosure rules, the alternate recipient generally is to be treated like a participant under each plan in which he or she is enrolled. Therefore, the alternate recipient should be sent copies of all applicable ERISA-required disclosures, including the summary plan description, summary of material modifications, summary annual report, WHCRA notices, etc. These items generally should be furnished to the alternate recipient's custodial parent or guardian. (If the alternate recipient is an adult, the plan administrator may provide copies to both the alternate recipient and the custodial parent or guardian.) Where an agency is involved (as in the case of a National Medical Support Notice), it may be necessary or appropriate to provide copies of these items to the agency as well. Note that the alternate recipient need not be counted as a participant for purposes of the annual report (Form 5500).

E. Effective Date of Enrollment

An alternate recipient generally will be enrolled in the plan as of the next regular enrollment date under the plan (i.e., the date on which the plan regularly adds new participants and beneficiaries) following the plan administrator's approval of an order as a QMCSO (or the date provided in the order, if later) and receipt of any necessary enrollment forms. (If an employee is eligible for the plan but is not enrolled, he or she will also be enrolled if his or her enrollment is necessary for the alternate recipient to have the coverage required under the QMCSO.) However, if the employee has not yet satisfied the plan's waiting period, enrollment of the alternate recipient and employee will be delayed until the employee has completed the waiting period. Coverage is effective as of the date of enrollment.

F. Special Consideration - Child Already Enrolled

The parties may submit an order (including a National Medical Support Notice) that purports to require that a child be covered under a plan in which he or she is already enrolled. In this circumstance, the plan administrator should process the

order under these procedures but should also inform the parties of the child's status as a current beneficiary under the plan.