The sample QMCSO procedures and checklist that follow are intended to assist a Plan Administrator in determining whether a particular order is a QMCSO and in carrying out its responsibilities relating to QMCSOs. They have been designed to comply with the requirements of ERISA §609 and to incorporate the rules regarding the processing of National Medical Support Notices.

Caution: This sample document is for a hypothetical organization and it may not apply exactly to your factual situation. It is provided for illustrative purposes only, and it is not incorporated into the Plan "as-is". If you wish to use this sample as a starting point for your own document, advice of legal counsel is recommended before adopting the procedures as part of the Plan officially.

Article I. Introduction

This Attachment sets forth the procedures to be followed by the group health plan(s) 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. What Is a QMCSO?

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. Typically, such orders are drafted by divorce lawyers and may vary widely in terminology, format, and sophistication.

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. What Are the 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 (and should 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.

Article 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.

- ***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.

- ***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—see subsection A.1), 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 Order will be reviewed as if it is a newly submitted Order.

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, if required under the plan.

- A change in the participant's cafeteria plan election, if applicable. If benefits required to be provided under a QMCSO are paid for on a pre-tax basis, the QMCSO may qualify as a permitted election change event under the company's cafeteria plan. If applicable, and if the cafeteria plan document permits an election change on account of the QMCSO, the participant may submit a change in his or her cafeteria plan election in accordance with the cafeteria plan's rules.

- 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. For example, payments might be required concurrent with each payroll period or on a monthly basis as required of qualified beneficiaries receiving COBRA continuation coverage. The plan administrator should also make sure that it has contact information for the person or entity that 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 4 QMCSO Procedures for Group Health Plans 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. **Preexisting Condition Exclusions**

Health care reform amended the rules under HIPAA relating to the imposition of preexisting condition exclusions. Generally effective for plan years beginning on or after September 23, 2010, health care reform prohibits group health plans and group health insurance issuers from imposing any preexisting condition exclusion on individuals under age 19. This prohibition becomes effective for all individuals regardless of age for the first plan year beginning on or after January 1, 2014. These rules apply regardless of whether the group health plan or group health plan coverage is grandfathered. As a result, once fully effective, no preexisting condition exclusion can be imposed on any new enrollee, including an alternate recipient. To the extent the health care reform rules are not effective, the HIPAA following rules relating to preexisting conditions continue to apply.

Unless the alternate recipient is a newborn or newly adopted child (or a child newly placed for adoption) and is enrolled within 30 days of the birth, adoption, or placement, the plan's preexisting condition exclusion (PCE) provision, if any, will apply to an alternate recipient under a QMCSO to the same extent it would apply to any other new enrollee.

- If the alternate recipient was not eligible for coverage before the QMCSO was in effect, a 12-month PCE will apply, subject to credit for creditable coverage.

- If the alternate recipient was eligible but not enrolled prior to the QMCSO, then an 18-month PCE period generally will apply. However, if the alternate recipient (1) was not enrolled due to coverage from another source and (2) lost coverage under circumstances that would qualify for special enrollment, then the alternate recipient may qualify for the shorter 12-month PCE that applies to special enrollees.

F. 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 5 QMCSO Procedures for Group Health Plans 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.

G. 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.

H. Plans With Multiple Options

An otherwise-qualified order may identify a plan or type of coverage with multiple options without designating the option in which the alternate recipient is to be enrolled or the manner in which an option is to be chosen. In the case of a National Medical Support Notice, the administrator should follow the instructions in the Notice regarding plans with multiple options. For other orders, the plan administrator should enroll the alternate recipient in the same option as the employee if the employee is enrolled in the plan. Otherwise, the plan administrator may follow procedures similar to those in the National Medical Support Notice. That is, the plan administrator may, instead of rejecting the order, provide the parties with information about the available options and direct them to make a selection. If the plan has a default option, the plan administrator may also notify the parties that the alternate recipient and employee will be enrolled in this option if a response is not received within a specified time period (e.g., 20 business days).

Checklist for Assessing Whether an Order Is a QMCSO

ERISA §609 requires group health plans to honor the terms of a qualified medical child support order (QMCSO). The determination as to whether an order is "qualified" is made by the Plan Administrator.

This checklist will help determine whether an order meets the requirements of a QMCSO in accordance with ERISA §609(a).

This checklist sets out those items that must be present for an order (including a National Medical Support Notice) to be a QMCSO. The plan administrator should complete this checklist as soon as possible after receiving such an order. If all items are present, the parties (including the issuing agency, in the case of a National Medical Support Notice) shall be notified that the order is a QMCSO. If one or more items are not present, the parties (including the issuing agency, in the case of a National Medical Support Notice) shall be notified that the order is not a QMCSO.

Complete a separate checklist for each plan to which the order applies.

The term "you" or "your" in this checklist refers to the Plan Administrator.

☐ 1. Is the Document a Medical Child Support Order?

The order must be a judgment, order or decree (including approval of a settlement agreement) that (a) provides for child support or health benefit coverage for a child of a participant under a group health plan, is made pursuant to state domestic relations law, and relates to benefits under the plan; or (b) enforces a state law relating to medical child support described in Section 1908A of the Social Security Act (which requires states to enact certain medical child support laws in order to receive federal Medicaid funds). The order may be issued by a court of competent jurisdiction or through an administrative process that has the force and effect of law under applicable state law. The order may be a National Medical Support Notice. Agreements made by the parties but not formally approved by a court are not acceptable.

A note on revised orders: If an order was initially rejected as not qualified and the deficiencies are later corrected by the parties, a revised order may be submitted to the plan. However, the revised order must have been formally approved by the court or administrative agency to be qualified.

☐ 2. If the Order Is a National Medical Support Notice, Does It Include the Following?

A properly completed National Medical Support Notice will automatically qualify as a QMCSO if all of the specified information is filled out. This is because such Notices are prepared using a standard form that was jointly developed by the DOL and HHS. The instructions on the Notice should be followed in evaluating whether the Notice constitutes a valid QMCSO order qualifies and for providing an appropriate response to the issuing agency and the other parties. In general, a Notice must include—

- The name and address of the child (a state official's name and address may be substituted for the address of the child);
- The name and address of an employee who is enrolled in the plan or eligible for enrollment; and
- The name of the issuing agency.

In addition, the Notice must identify an underlying child support order and may not require benefits for an alternate recipient who is at or above the age at which dependents are no longer eligible for coverage under the plan or where the employee is in a class of employees that is not eligible for the plan. The form of the Notice is designed so as to automatically satisfy the other requirements of a QMCSO (i.e., items 3.b, c, and e below).

☐ 3. If the Order Is Not a National Medical Support Notice, Does it meet the Following Requirements?

☐ a. Does the Order Include All Necessary Names and Addresses?

The order must include the names and last-known mailing addresses of the participant and each alternate recipient (i.e., each child of the participant who is recognized under the order as having a right to enroll under a group health plan with respect to the participant). (In some cases, there may be multiple alternate recipients.) However, the order may substitute the name and mailing address of an official of a state or political subdivision for the mailing address of an alternate recipient. An order may also designate a guardian or other representative of an alternate recipient (for example, the custodial parent or another adult who cares for the minor child) to receive copies of notices that are sent to an alternate recipient with respect to an order.

Although the law requires the order to state the parties' names and addresses, an order that misstates factual identifying information (e.g., the order misstates a name or omits an address) should not be rejected if you can readily determine or access the correct information.

☐ b. Does the Order Provide a Reasonable Description of the Coverage to Be Provided?

In general, the order should either provide a reasonable description of the type of coverage to be provided by the plan to each alternate recipient or indicate the manner in which the type of coverage is to be determined. To the extent that the order identifies a plan or type of coverage for which there is only one benefit option, this requirement is met. An order would also satisfy this requirement by designating the alternate recipient's coverage to be the same as the coverage elected each year by the participant/parent. An order that identifies a plan or type of coverage with multiple options may also designate the option in which the alternate recipient is to be enrolled or the manner in which an option is to be chosen.

In the absence of such a designation under an otherwise-qualified order that applies to a plan with multiple options, the plan administrator should enroll the alternate recipient in the same option as the employee if the employee is enrolled in the plan. Otherwise, the plan administrator may follow procedures similar to those in the National Medical Support Notice. That is, the plan administrator may, instead of rejecting the order, provide the parties with information about the available options and direct them to make a selection. If the plan has a default option, the plan administrator may also notify the parties that the alternate recipient and employee will be enrolled in this option if a response is not received within a specified time period (e.g., 20 business days).

It is acceptable for an order to refer to an outdated or informal plan name, or not to name a plan. The plan's letter to the parties regarding whether the order is a QMCSO should state the proper name of the plan(s) covered by the order.

☐ c. Does the Order Identify the Period to Which It Applies?

While the order must indicate the period to which it applies, it need not include a specific ending date. For example, it is acceptable for an order to indicate that it expires when the child attains age 18 or upon the employee's ineligibility for coverage (if earlier). The period during which the order is effective might also be inferred from the context of the order. Note that coverage under a QMCSO need not continue beyond the age for which coverage is available for dependents generally.

☐ d. Is the Child Eligible for Coverage Under the Plan?

The order may not override other plan provisions generally applicable to dependent coverage. For example, a child may not qualify for coverage under the plan because—

- The child does not meet the plan's definition of "dependent child" because of age or student status;
- The plan does not provide dependent coverage; or

- The employee is not eligible to participate in the plan (due to part-time status, termination of employment, etc.). (Note that an employee who is eligible for coverage but is not enrolled must be enrolled if necessary for an alternate recipient to have coverage pursuant to a QMCSO.)

☐ e. Does the Order Require the Plan to Provide Benefits Not Available Under the Plan?

The order may not require a plan to provide a type or form of benefit or option not otherwise provided, except as necessary to comply with the requirements of a state law relating to medical child support described in Section 1908A of the Social Security Act. For example, an order cannot require a plan that provides only medical benefits to provide dental benefits to an alternate recipient. Similarly, an order cannot require a waiver of a plan's cost-sharing provisions or coverage for specific conditions, supplies, or services not otherwise covered.

☐ 4. Does Any Required Employee Contribution Exceed Applicable State and Federal Withholding Limits?

A determination must be made as to whether any required employee contribution exceeds applicable state and federal limits. If the order is a National Medical Support Notice, the limitations should be specified in the Notice. Otherwise, a plan must ensure that it does not withhold amounts for coverage that exceed the maximum amount permitted under the Consumer Credit Protection Act (CCPA). Under the CCPA, an employer cannot withhold more than (a) 50% of the employee's disposable weekly earnings where the employee is supporting a spouse or dependent child (other than the potential alternate recipient); or (b) 60% of the employee's disposable weekly earnings where the employee is not supporting a spouse or other child. Applicable state-law wage withholding limitations, which may be even more restrictive than the CCPA, must also be reviewed.

Where the cost of coverage exceeds the amount that can be withheld, coverage need not (and should not) be extended (unless contributions are made from another source—e.g., a state agency). If the amount required to pay for the child's coverage cannot be withheld, the custodial parent (as well as the child support enforcement agency, if one is involved) should be notified. (The National Medical Support Notice includes a form to be used for notifying the agency of the inability to withhold sufficient funds due to withholding limitations.) The custodial parent and/or agency may be able to modify the employee's other support obligations in order to allow for sufficient withholding to pay for the child's coverage. The participant may also voluntarily consent to withholding in excess of applicable limitations.