CHICAGO REGIONAL COUNCIL OF CARPENTERS
WELFARE FUND

QUALIFIED MEDICAL CHILD SUPPORT ORDER GUIDELINES AND PROCEDURES

Guidelines for Creating Qualified Medical Child Support Orders (including National Medical Support Notices, addressed in Exhibit A)

1. What is a "qualified medical child support order"?

A "qualified medical child support order" ("QMCSO") is a court judgment, decree or order to provide coverage for an "alternate recipient" (child of a participant, including an adopted child and a child placed for adoption with the participant) under the Chicago Regional Council of Carpenters Welfare Fund ("Plan") health benefits.

There are two kinds of QMCSOs:

- QMCSOs which enforce state Medicaid laws. These must be in the form of a National Medical Support Notice ("NMSN"), as adopted by the federal Office of Child Support Enforcement. NMSN procedures and checklist are attached as Exhibit A.

- QMCSOs issued under state domestic relations laws. To be "qualified", a medical child support order must meet the requirements outlined in ERISA section 609(a), which are briefly described below.

2. According to ERISA, what information must a QMCSO contain?

- The full name and last known mailing address of the participant who is covered under the Plan.

- The full name and last known mailing address of each alternate recipient who is to receive coverage under the terms of the medical child support order. Where appropriate, the mailing address of the alternate recipient may be in care of a state agency. In addition, although not specified in ERISA, the medical child support order should contain the Social Security number and date of birth of each alternate recipient which is necessary to proper plan administration.

- The name and address of the representative designated to receive notices on behalf of the alternate recipient. (This will usually be the custodial parent or legal guardian of the alternate recipient.)

- The type of coverage to be received by each alternate recipient under the Plan.

- The name of the party who will pay the premiums (if any) for the coverage.

- The period to which the medical child support order applies.

- The name of the plan to which the medical child support order applies.

3. What other requirements must a QMCSO meet under ERISA?

A medical child support order must not require the Plan to provide any type or form of benefit, or any option, not otherwise provided by the Plan. For example, if the participant is not eligible to elect coverage for dependents, a medical child support order cannot force the Plan to provide dependent coverage.

4. What type of coverage is available under the Plan?

The Plan provides the following types of health care coverage: medical, prescription drug, and dental and vision benefits. If a medical child support order is received by the Plan which specifies only that "health" coverage be provided, the Plan will interpret this to mean that only the level of benefits in effect for the alternate recipient's parent is to be provided to the alternate recipient. For example, some benefit groups are not eligible for all benefits (*e.g.*, dental and vision benefits are not offered to retirees). The alternate recipient's parent must be a participant covered under the Plan.

5. Who pays for the alternate recipient's coverage?

The Plan is not required to make coverage available to the alternate recipient unless the coverage is paid for. The medical child support order should provide that the participant will make the necessary arrangements with the Plan to enroll the child. If payments are to be made from another source, the medical child support order should identify the responsible party and the outside payer would contact the Plan to schedule payments. However, the Plan only accepts Employer contributions from active participants while retirees make self-payments.

In the absence of any information in the medical child support order on this issue, the Plan will assume that the participant is responsible for payment, and will enforce the medical child support order accordingly.

6. How much will the alternate recipient's coverage cost?

The cost of the alternate recipient's coverage depends on the benefits available to the participant. It also depends on (1) whether the participant already has coverage, and (2) whether the participant will cover the alternate recipient as a dependent or as a special QMCSO beneficiary. The parties should contact the Plan for more information.

7. When will the alternate recipient's coverage begin?

Coverage can begin no earlier than the date a valid QMCSO is received by the Plan, or such later date specified in the medical child support order, [provided contributions or premiums are paid on a timely basis.]

8. When will the alternate recipient's coverage end?

Coverage for the alternate recipient under the medical child support order will end on the earliest of the following dates:

- The date the participant is no longer eligible to cover dependents under the Plan.
- The date (including any grace periods) that payment for coverage is due but unpaid.
- The date the alternate recipient dies.
- The date the alternate recipient no longer meets the definition of an eligible dependent child under the terms of the Plan.
- The date the alternate recipient experiences some other event as specified in the order; *e.g.*, attaining a limiting age, getting married, or becoming financially self-sustaining.

The medical child support order must provide that the participant and/or the alternate recipient's custodial parent, legal guardian, or sponsoring state agency will notify the Plan when such an event occurs.

If the alternate recipient's coverage would end due to a qualifying event, then COBRA rights for continuation of coverage may apply.

Procedures for Reviewing
Qualified Medical Child Support Orders

National Medical Support Notice (NMSN)

Upon receipt of a medical child support order that is in the form of an NMSN, the Plan will follow the procedures outlined in the NMSN Procedures attached hereto as Exhibit A.

Non-NMSN Medical Child Support Orders

Upon receipt of a medical child support order that is not in the form of an NMSN, the Plan will follow the procedures outlined below.

Medical Child Support Order Acknowledgment

When the Plan receives a medical child support order which is not an NMSN, the Plan will perform the following functions as promptly as possible:

- Notify the participant and alternate recipient (through its designated representative) that the Plan has received the medical child support order. Copies of the notice shall also be sent to legal counsel, if names and addresses of the attorneys are made available.

- Send a copy of these procedures to the parties and their respective counsel.

Determination of Medical Child Support Order's Status

1. The Plan will determine whether the medical child support order is qualified pursuant to the Plan's guidelines for creating QMCSOs within a reasonable period of time after receipt of the medical child support order. This period will not exceed 40 days from the date of receipt of the medical child support order, unless extenuating circumstances apply.

2. If the Plan determines that the medical child support order is not qualified, the Plan will advise the parties to the medical child support order and their respective counsel that the medical child support order is not qualified. The Plan will explain the specific provisions which support its determination. The Plan will also explain how the parties can request a review of the determination.

3. If the Plan determines that the medical child support order satisfies all of the requirements for a QMCSO, the Plan will:

   - Notify each party and respective counsel that the medical child support order is qualified; and

   - Notify each party with regard to the procedure to request a review of the determination.

4. Take such steps to enforce the QMCSO, subject to the review procedures described below.

   - An alternate recipient shall be treated as a participant for purposes of meeting applicable reporting and disclosure requirements.

   - An alternate recipient shall be required to comply with all applicable Plan rules and procedures, including procedures relating to application for benefits, disclosure of information by participants and beneficiaries, and dispute resolution and appeal.

   - Any payment for benefits made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by an alternate recipient or an alternate recipient's custodial parent or legal guardian shall be made to the alternate

recipient, or the alternate recipient's custodial parent or legal guardian, subject to provider benefit assignments.

Request and Procedures for Review

1. If any interested party disputes the Plan's determination that the medical child support order is or is not qualified, that party must file a written request for review with the Plan within 60 days of the date of the determination letter. The request for review should provide:

   - A statement of the ground(s) for the request for review;
   - Specific reference to the pertinent provision or provisions of the Plan or ERISA on which the request for review is based;
   - A statement of the argument(s) and authority (if any) supporting each ground for the request for review; and
   - Any other pertinent documents or comments which the party desires to submit in support of the request for review.

2. Within a reasonable time after a party files a timely request of review, the Plan shall notify all interested parties of the request.

   The Plan generally renders a decision within 60 days after receiving the request for review, unless special circumstances require an extension of time for processing the request. The decision shall be communicated in writing to all interested parties, and shall include the specific reasons for the decision and references to the appropriate provisions of the Plan or ERISA.

   No participant or alternate recipient may commence legal action to challenge the determination of the status of a medical child support order, or the amount of benefits payable under the terms of a QMCSO, until the participant or alternate recipient has exhausted all review procedures provided in this section.

For More Information

Inquiries and medical child support orders submitted for review should be directed to the following address:

Active Plan of Benefits:
Chicago Regional Council of Carpenters Welfare Fund
Attn: Health Benefits Department
12 East Erie Street
Chicago, IL 60611
(312) 787-9455, Menu Option 3

Retiree Plan of Benefits:
Chicago Regional Council of Carpenters Welfare Fund
Attn: Retirement Benefits Department
12 East Erie Street
Chicago, IL 60611
(312) 787-9455, Menu Option 4

EXHIBIT A

CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND

Procedures for Responding to a National Medical Support Notice (NMSN)

1. Overview. The National Medical Support Notice ("NMSN") contains the procedures to be followed by employers and plan administrators when an employee is subject to a qualified medical child support order ("QMCSO"). If the NMSN is appropriately completed by the child support agency, it is deemed to be a valid QMCSO. The NMSN form consists of two parts, Part A and Part B. The child support agency forwards Part A to the employer for withholding purposes. The employer forwards Part B to the Chicago Regional Council of Carpenters Welfare Fund ("Plan") to enroll the eligible child(ren). The employer has the responsibility for determining if the required withholding meets state and federal limitations and should note any limitations on Part B. The Plan administrator must complete Part B and return it to the issuing agency within 40 business days after the date of the NMSN, or sooner if reasonable.

2. Procedures. Upon receipt of Part B of the NMSN, the Plan administrator should complete the following steps:

   (a) Check the Validity of the NMSN. Generally, an NMSN is valid if it meets the following requirements:

   - Contains the name of the issuing state agency;
   - Specifies the name and last known mailing address of a participant who is covered under the Plan. If a mailing address is not present, but reasonably accessible, the NMSN cannot be deemed invalid on that basis alone;
   - Contains the name and mailing address of one or more alternate recipients (i.e., the child(ren) of the participant covered by the NMSN) or the mailing address of a substituted official or agency in regard to the alternate recipient(s). If a mailing address is not present, but reasonably accessible, the NMSN cannot be deemed invalid on that basis alone;
   - Identifies an underlying child support order; and
   - Contains a reasonable description of the term and type of coverage that the Plan must provide to each alternate recipient, or the manner in which such coverage is to be determined. The NMSN satisfies these requirements where the issuing agency identifies either the specific type of coverage or all available group health

coverage. If the NMSN does not designate either the specific type of coverage or all available coverage, the employer and Plan administrator should assume that all are designated.

(b) Determine Whether Each Child Listed as an Alternate Recipient Is Eligible to Be Enrolled in the Plan as a Dependent. The Plan will determine if each child meets the Plan's definition of a dependent child and whether the employee is eligible to participate in the Plan. The Plan cannot deny enrollment on the grounds 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; (3) the child does not reside with the participant or in the Plan's service area; or (4) the child is receiving benefits under the state Medicaid plan.

(c) Period of Coverage. The child(ren) is treated as a dependent under the terms of the Plan. Therefore, coverage of a child(ren) as a dependent(s) will end when similarly situated dependents are no longer eligible for coverage under the Plan. The Plan is obligated to provide only those benefits that it provides to any dependent of a participant who is enrolled in the Plan.

(d) Complete Part B of the NMSN and Provide Required Notices.

(i) Invalid Form. If the NMSN is invalid, complete Response 5 of Part B and

- Send the completed Part B to the issuing agency within 40 business days of the date of the NMSN;
- Notify the employer (send a copy of the completed Part B), unless the employee is retired;
- Inform the noncustodial parent (generally the participant), the custodial parent and each child of the reasons for the determination. Notification to the custodial parent will be deemed notification to the child(ren) if they reside at the same address; and
- Enclose a copy of the summary plan description to apprise interested parties of their ERISA rights.

(ii) Valid Form and Eligible Participant and Dependents. If the NMSN is valid and the participant and dependents are eligible (or already covered), complete Response 1 and Response 2 or 3 of Part B and

- Send the completed Part B to the issuing agency within 40 business days of the date of the NMSN; and

- Notify the employer (forward a copy of the completed Part B with cost information), unless the employee is retired.

In addition, if the Plan completed Response 2,

- Enroll the child(ren) in the Plan;

- Inform the noncustodial parent (generally the participant), the custodial parent and each child of the enrollment or continued coverage. Notification to the custodial parent will be deemed notification to the child(ren) if they reside at the same address;

- Send the custodial parent a description of the coverage, summary plan description and any forms, document or information necessary to effectuate the coverage, as well as information necessary to submit claims for benefits; and

- Enclose a copy of the summary plan description to apprise interested parties of their ERISA rights.

Alternatively, if the Plan completed Response 3,

- Send the issuing agency copies of the applicable summary plan descriptions, contribution information and any other documents that describe available coverage under each option of the Plan, including information on a limited service area for any option under the Plan.

- Enroll the child(ren) in the Plan's default option (if any), if the Plan does not receive a response from the issuing agency within 20 business days of the date the Plan returned Part B. If the Plan does not have a default option, the Plan should wait to hear from the issuing agency.

- Inform the noncustodial parent (generally the participant), the custodial parent and each child of the enrollment. Notification to the custodial parent will be deemed notification to the child(ren) if they reside at the same address;

- Send the custodial parent a description of the coverage, summary plan description and any forms, document or

information necessary to effectuate the coverage, as well as information necessary to submit claims for benefits; and

- Enclose a copy of the summary plan description to apprise interested parties of their ERISA rights.

(iii) Valid Form, But Ineligible Dependent. If the NMSN is valid, but the child(ren) does not meet the Plan's definition of a dependent, complete Response 1 and Response 5 of Part B and

- Send the completed Part B to the issuing agency within 40 business days of the date of the NMSN;

- Notify the employer (forward the completed Part B), unless the employee is retired;

- Inform the noncustodial parent (generally the participant), the custodial parent and each child of the reasons for your determination. Notification to the custodial parent will be deemed notification to the child(ren) if they reside at the same address; and

- Enclose a copy of the summary plan description to apprise interested parties of their ERISA rights.

(iv) Valid Form, But Ineligible Participant. If the NMSN is valid, but the participant is ineligible for coverage, complete Response 1 and Response 4 of Part B and

- Send the completed Part B to the issuing agency within 40 business days of the NMSN;

- Notify the employer (forward the completed Part B), unless the employee is retired;

- Inform the noncustodial parent (generally the participant), the custodial parent and each child of the reasons for your determination. Notification to the custodial parent will be deemed notification to the child(ren) if they reside at the same address;

- Enclose a copy of the summary plan description to apprise interested parties of their ERISA rights; and

- Keep a copy of Part B so the Plan can re-send it to the issuing agency at the appropriate time (see below).

NOTE: Complete Response 4 only if the participant is subject to a waiting period that expires more than 90 days from the date of receipt of the NMSN, or has not completed a waiting period whose duration is determined by the completion of the number of hours worked, etc. If the waiting period is less than 90 days, complete Response 2.

If the participant becomes eligible for coverage at a later date and the Plan administrator determined that the child(ren) meets the criteria for being a dependent under the Plan, complete Response 1 and Response 2 or 3 of Part B and

- Send the completed Part B to the issuing agency within 40 business days of the NMSN;
- Enroll the child(ren) in the Plan;
- Notify the employer (forward the completed Part B with the cost of coverage), unless the employee is retired;
- Inform the noncustodial parent (generally the participant), the custodial parent and each child of the enrollment or continued coverage. Notification to the custodial parent will be deemed notification to the child(ren) if they reside at the same address;
- Send the custodial parent a description of the coverage, summary plan description and any forms, document or information necessary to effectuate the coverage, as well as information necessary to submit claims for benefits; and
- Enclose a copy of the summary plan description to apprise interested parties of their ERISA rights.

For More Information

Inquiries and National Medical Support Notices submitted for review should be directed to the following address:

Active Plan of Benefits:
Chicago Regional Council of Carpenters Welfare Fund
Attn: Health Benefits Department
12 East Erie Street
Chicago, IL 60611
(312) 787-9455, Menu Option 3
(312) 951-1515 (Fax)

Retiree Plan of Benefits:
Chicago Regional Council of Carpenters Welfare Fund
Attn: Retirement Benefits Department
12 East Erie Street
Chicago, IL 60611
(312) 787-9455, Menu Option 4
(312) 951-3986 (Fax)