MATRIX PROVIDERS, INC.

Qualified Medical Child Support Order
And National Medical Support Notice
Administrative Procedures

Introduction

1. A group health plan subject to the Employee Retirement Income Security Act ("ERISA") must comply with a qualified medical child support order ("QMCSO"). A group health plan is an employee welfare benefit plan providing medical care to participants or beneficiaries directly or through insurance, reimbursement or otherwise.

2. A QMCSO is a judgment, decree or order issued by a court or through a state administrative process that requires a group health plan to provide coverage for an "alternate recipient."

3. An alternate recipient includes the participant's child, adopted child or a child placed for adoption with the participant.

4. Under ERISA, a group health plan must establish reasonable procedures to determine whether medical child support orders are QMCSOs and to administer the provision of benefits under qualified orders.

5. These QMCSO procedures apply to the Matrix Providers Employee Welfare Benefit Plan Medical Plan (the "Plan"). The Plan is administered by Matrix Providers, Inc. (the "Plan Administrator").

6. There are two types of QMCSOs:

   (a) National Medical Support Notice. The National Medical Support Notice ("NMSN") is the exclusive document a state child support enforcement agency must use to enforce the health care coverage provisions of child support orders. The Child Support Performance and Incentive Act generally requires state child support enforcement agencies to use this standardized notice. ERISA regulation section 2590.609-2 discusses the requirements of a NMSN.

   (b) QMCSOs issued under state domestic relations laws. These must meet the requirements outlined in ERISA section 609(a). The ERISA requirements are described below.

Questions and Answers About QMCSOs

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

   (a) The Plan participant's full name and last known mailing address.

   (b) Each alternate recipient's full name and last known mailing address who will receive coverage under the medical child support order. Where appropriate, the alternate recipient's mailing address may be in care of a state agency. Although not required by ERISA, the medical child support order should contain each alternate recipient's social security number and date of birth which is necessary for proper Plan administration.

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

   (d) The type of coverage each alternate recipient will receive under the Plan.

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

   (f) The period to which the medical child support order applies.

   (g) The name of the plan to which the medical child support order applies.

2. 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. If the participant is not eligible to elect coverage for dependents, a medical child support order cannot force the Plan to provide dependent coverage.

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

   (a) The Plan provides the following types of health care coverage: medical benefits, prescription drug benefits, dental benefits and vision benefits and any applicable employee assistance program benefits.

   (b) If a medical child support order specifies only that "health coverage" be provided, the Plan Administrator will interpret "health coverage" only as medical, prescription drug, dental, vision, and any applicable employee assistance program coverages.

   (c) If a medical child support order states the Plan Administrator should enroll the alternate recipient in the "highest level" of benefits or "lowest cost" benefits, the Plan Administrator will determine that the order is not

specific enough. The medical child support order specifically should state the level of benefits the alternate recipient will receive under the Plan.

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

   (a) The Plan Administrator is not required to make coverage available to the alternate recipient unless the participant (or another individual) pays for the coverage.

   (b) The medical child support order should provide that the participant will make the necessary arrangements with the Plan Administrator to enroll the child.

   (c) If another source is responsible for payments, the medical child support order should identify the payer.

   (d) Any non-participant payer should contact the Plan Administrator to schedule payments.

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

5. 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. The parties should contact the Plan Administrator for more information.

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

   (a) Coverage can begin no earlier than the date the Plan Administrator receives a valid QMCSO or such later date specified in the medical child support order, provided contributions are paid on a timely basis.

   (b) If the employee has not already enrolled in the Plan, the employee will be required to enroll her- or himself at the same time that (s)he enrolls the alternate recipient. The Plan does not allow a child to be covered other than as the employee's dependent, except as required by the Consolidated Omnibus Budget Reconciliation Act ("COBRA").

7. 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:

   (a) The date the participant is no longer eligible to cover dependents under the Plan.

(b) The date (including any grace periods) that payment for coverage is due but unpaid.

(c) The date the alternate recipient dies.

(d) The date the alternate recipient no longer meets the definition of an eligible dependent under the terms of the Plan.

(e) 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 Administrator when such an event occurs.

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

Procedures for Medical Child Support Orders which are not National Medical Support Notices

If the Plan Administrator receives a medical child support order that is not in the form of a National Medical Support Notice, the following procedures will apply:

1. Acknowledge the Medical Child Support Order. When the Plan Administrator receives a medical child support order, it will perform the following functions as promptly as possible:

   (a) Notify the participant and alternate recipient (through his/her designated representative) that the Plan Administrator received the medical child support order. The Plan Administrator also will send a copy of the notice to the attorneys, if the attorneys' names and addresses are made available.

   (b) Send a copy of these procedures to the parties and their attorneys.

2. Determine Medical Child Support Order's Status.

   (a) The Plan Administrator will determine whether the medical child support order is qualified pursuant to these procedures. The Plan Administrator will make this determination within a reasonable period of time after it receives the medical child support order. This period will not exceed 40 days from the date the Plan Administrator receives the medical child support order, unless extenuating circumstances apply.

(b) If the Plan Administrator determines that the medical child support order is not qualified, it will advise the parties and their attorneys of this determination. The Plan Administrator also will explain the specific provisions which support its determination and explain how the parties can request a review of the determination.

(c) If the Plan Administrator determines the medical child support order satisfies all of the requirements for a QMCSO, it will:

(i) Notify the parties and their attorneys that the medical child support order is qualified;

(ii) Explain the procedure to request a review of the determination; and

(iii) Take such steps to enforce the QMCSO, subject to the review procedures described below.

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

[b] 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 claims and appeals.

Any payment for benefits made by the Plan pursuant to a QMCSO for reimbursement of 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.

3. Request and Procedures for Review.

(a) If any interested party disputes the Plan Administrator's determination that the medical child support order is or is not qualified, that party should 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:

(i) A statement of the ground(s) for the request for review;

(ii) Specific reference to the pertinent provision or provisions of the Plan or ERISA on which the request for review is based;

(iii) A statement of the argument(s) and authority (if any) supporting each ground for the request for review; and

(iv) Any other pertinent documents or comments which the party desires to submit in support of the request for review.

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

(c) The Plan Administrator shall render a decision within 60 days after receiving the request for review, unless special circumstances require an extension of time for processing the request (and then not later than 120 days after the request for review). 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.

(d) 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 these review procedures.

National Medical Support Notices ("NMSN")

If the Plan Administrator receives a medical child support order that is in the form of an NMSN, the following procedures will apply.

1. Overview. A QMCSO which enforces state Medicaid laws must be in the form of a NMSN. If the NMSN is appropriately completed by the child support agency, it is deemed to be a valid QMCSO.

   The NMSN contains separate procedures the Employer and Plan Administrator must follow. The 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 Plan Administrator to enroll the eligible child. The Employer must determine 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. (If the Employer also serves as the Plan Administrator, the employer should complete Part B.) ERISA section 609 and its regulations contain a copy of the NMSN, including Parts A and B and their instructions.

2. Part A Procedures. Within 20 business days after the date of the NMSN *(see* "Date of Notice" on Parts A and B), the Employer must review the NMSN and take the following actions:

(a) The Employer should mark the appropriate box on the Employer Response to Part A and return it to the issuing agency if any of the following statements are true:

(i) The Employer does not maintain or contribute to a plan that provides dependent coverage;

(ii) The named employee is among a class of employees that is not eligible for a plan that provides dependent coverage; or

(iii) The named employee is not an employee of the Employer.

(b) The Employer must retain Part A and transfer Part B of the NMSN to the Plan Administrator. Where the Employer also serves as Plan Administrator, the employer should complete Part B. If the Plan Administrator determines the NMSN is valid, the Employer then must determine whether the employee's share of the premium/contribution can be withheld from pay. If the required premium/contribution cannot be withheld due to state or federal withholding limitations, the Employer must use the Employer Response to Part A to notify the issuing agency.

3. Part B Procedures. When the Plan Administrator receives Part B of the NMSN, it should complete the following steps:

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

(i) Contains the name of the issuing state agency;

(ii) Specifies the participant's name and last known mailing address. If a mailing address is not present, but reasonably accessible, the NMSN cannot be deemed invalid on this basis alone;

(iii) Contains each alternate recipient's name and mailing address or the mailing address of a substituted official or agency on the alternate recipient's behalf. If a mailing address is not present, but reasonably accessible, the NMSN cannot be deemed invalid on this basis alone;

(iv) Identifies an underlying child support order; and

(v) Contains a reasonable description of the term and type of coverage 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 available coverage, the Employer and the 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 Administrator should 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 Administrator cannot deny enrollment on the grounds that (i) the child was born out of wedlock; (ii) the child is not claimed as a dependent on the participant's federal income tax; (iii) the child does not reside with the participant or in the Plan's service area; or (iv) the child is receiving benefits under the state Medicaid plan.

(c) Period of Coverage. The child is treated as a dependent under the terms of the Plan. Therefore, the child's coverage as a dependent 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:

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

[b] Notify the Employer (send a copy of the completed Part B);

[c] Inform the noncustodial parent (generally the participant), the custodial parent and each child of the reasons for the determination. Notice to the custodial parent will be deemed notice to the child, if (s)he resides at the same address as the custodial parent. The Plan Administrator may satisfy this notice requirement by sending a copy of the Plan Administrator Response to Part B; and

[d] Enclose a copy of the summary plan description to apprise interested parties of their ERISA rights and a copy of these QMCSO procedures.

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

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

[b] Notify the employer (forward a copy of the completed Part B with cost information).

In addition, if the Plan Administrator completed Response 2,

[c] Enroll the child in the Plan;

[d] Inform the noncustodial parent (generally the participant), the custodial parent and each child of the enrollment or continued coverage. Notice to the custodial parent will be deemed notice to the child, if (s)he resides at the same address as the custodial parent. The Plan Administrator may satisfy this notice requirement by sending a copy of the Plan Administrator Response to Part B;

[e] 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

[f] Enclose a copy of the summary plan description to apprise interested parties of their ERISA rights and a copy of these QMCSO procedures.

Alternatively, if the Plan Administrator completed Response 3,

[g] 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;

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

[i] Inform the noncustodial parent (generally the participant), the custodial parent and each child of the enrollment. Notice to the custodial parent will be deemed notice to the child, if (s)he resides at the same address as the custodial

parent. The Plan Administrator may satisfy this notice requirement by sending a copy of the Plan Administrator Response to Part B;

[j] 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

[k] Enclose a copy of the summary plan description to apprise interested parties of their ERISA rights and a copy of these QMCSO procedures.

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

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

[b] Notify the Employer (forward the completed Part B);

[c] Inform the noncustodial parent (generally the participant), the custodial parent and each child of the reasons for your determination. Notice to the custodial parent will be deemed notice to the child, if (s)he resides at the same address as the custodial parent. The Plan Administrator may satisfy this notice requirement by sending a copy of the Plan Administrator Response to Part B; and

[d] Enclose a copy of the summary plan description to apprise interested parties of their ERISA rights and a copy of these QMCSO procedures.

(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:

[a] Send the completed Part B to the issuing agency within 40 business days of the NMSN;

[b] Notify the Employer (forward the completed Part B);

[c] Inform the noncustodial parent (generally the participant), the custodial parent and each child of the reasons for the determination. Notice to the custodial parent will be

deemed notice to the child, if (s)he resides at same address as the custodial parent. The Plan Administrator may satisfy this notice requirement by sending a copy of the Plan Administrator response to Part B;

[d] Enclose a copy of the summary plan description to apprise interested parties of their ERISA rights and a copy of these QMCSO procedures; and

[e] Keep a copy of Part B to re-send to the issuing agency at the appropriate time (see below).

Complete Response 4 only if the participant (a) is subject to a waiting period that expires more than 90 days from the date of receipt of the NMSN, or (b) 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 meets the criteria of a dependent under the Plan, complete Response 1 and Response 2 or 3 of Part B. See the instructions under *Valid Form and Eligible Participant and Dependent* for completing Response 2 or 3.

For More Information

Inquiries about Qualified Medical Child Support Orders or National Medical Support Notices should be sent to the Plan Administrator at the following address:

Matrix Providers, Inc.
1400 16th Street #400
Denver, CO 80202