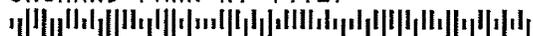


Date: August 15, 2015

IMMEDIATE ACTION REQUIRED

LAKE REGION MEDICAL

3902 CALIFORNIA RD
ORCHARD PARK NY 14127



New York Case Identifier: BW21435C1
Worker Code: EN07
RE No: 07
Employee Name: DUDEK, DAVID L
Employee SSN: 112-80-2406

**PLEASE CAREFULLY READ
ALL DOCUMENTS**

This package contains the following:

- 1) National Medical Support Notice (the "Notice") including Part A - Employer Response and Part B - Plan Administrator Response; and
- 2) Plan Administrator Response Addendum

Please be advised that receipt of this Notice constitutes legal service. The person or entity receiving this information is required to make every effort to ensure that these documents are submitted to the proper authority for completion. Failure of an employer or organization to comply with a qualified medical child support notice may result in legal action.

For an on-line income withholding calculator to determine the maximum amount of income you can withhold for child support and medical support please go to the New York State child support website at: childsupport.ny.gov.

Employers are required to:

Review Part A of the Notice, following the "Employer Response" instructions. If dependent health care benefits are **not available** to the employee named in the Notice or, the employee is no longer employed by this employer, the employer must complete Part A and return it to the Issuing Agency at the address provided above.

If dependent health care benefits are **available** to the employee, do not complete Part A. Forward Part B of the Notice and the Plan Administrator Response Addendum to the health care plan administrator. If the individual named in the Notice receives health care benefits through a union, the employer must forward this letter, Part B, and the Response Addendum to the organization, or union, providing those benefits and/or acting as the plan administrator.*

If you are the employer of the employee named above who maintains or contributes to dependent health care benefits that are administered through another organization, or union, you must immediately forward these documents to the benefits plan administrator of that organization or union for completion.

Plan Administrators, Labor Organizations or Unions providing benefits are required to:

Review and complete Part B of the Notice and the Plan Administrator Response Addendum and return the completed documents to the Issuing Agency at the address provided above.*

***Part B of the Notice must be completed and submitted even if the dependent health care benefits are already being provided.**

NATIONAL MEDICAL SUPPORT NOTICE - PART A

NOTICE TO WITHHOLD FOR HEALTH CARE COVERAGE

This Notice is issued under section 466(a)(19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974 (ERISA), and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998. Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable law. The information on the Custodial Parent and Child(ren) contained on this page is confidential and should not be shared or disclosed with the employee. NOTE: For purposes of this form, the Custodial Parent may also be the employee when the State opts to enforce against the Custodial Parent.

Issuing Agency: ERIE COUNTY SCU Issuing Agency Address: Medical Support Unit PO Box 15369 Albany NY 12212-5369 Notice Date: 08/15/2015 CSE Agency Case Identifier: BW21435C1 Telephone Number: 888-208-4485 Fax Number: 518-320-1081	Court or Administrative Authority: FAMILY COURT, COUNTY OF ERIE Order Date: 05/12/2015 Order Identifier: F1768614 Document Tracking Identifier: BW21435C1 Employer website: childsupport.ny.gov See NMSN Instructions: http://www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form
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Employer / Withholder's Federal EIN Number
LAKE REGION MEDICAL
 Employer / Withholder's Name
3902 CALIFORNIA RD
ORCHARD PARK NY 14127
 Employer / Withholder's Address
DURAND, JACLYN M
 Custodial Parent's Name (Last, First, MI)
96 WINSPEAR RD
WEST SENECA NY 14224
 Custodial Parent's Mailing Address

 Child(ren)'s Mailing Address (if different from Custodial Parent's)

 Name and Telephone of a Representative of the Child(ren)

RE: DUDEK, DAVID L
 Employee's Name (Last, First, MI)
112-80-2406
 Employee's Social Security Number
7873 CATHERINE ST
6: NY 14047
 Employee's Mailing Address

 Substituted Official/Agency Name

 Substituted Official/Agency Address
 (Required if Custodial Parent's Mailing address is left blank)

 Mailing Address of a Representative of the Child(ren)

Child(ren)'s Name(s)	Gender	DOB	SSN	Rec. No.
<u>DUDEK, EMMALYN R</u>	<u>F</u>	<u>08/13/2014</u>	<u>697-37-7968</u>	<u>01</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

The order requires the child(ren) to be enrolled in all health coverages available; or only the following coverage(s):
 Medical; Dental; Vision; Prescription drug; Mental health; Other (specify):

THE PAPERWORK REDUCTION ACT OF 1995 (P.L. 104-13) Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. **OMB control number: 0970-0222 Expiration Date: 08/31/2016.**

LIMITATIONS ON WITHHOLDING

The total amount withheld for both cash and medical support cannot exceed ____% of the employee's aggregate disposable weekly earnings. The employer may not withhold more under this National Medical Support Notice than the lesser of:

1. The amounts allowed by the Federal Consumer Credit Protection Act (15 U.S.C., section 1673(b));
2. The amounts allowed by the State of the employee's principal place of employment; or
3. The amounts allowed for health insurance premiums by the child support order, as indicated here:

The Federal limit applies to the aggregate disposable weekly earnings (ADWE). ADWE is the net income left after making mandatory deductions such as State, Federal, local taxes; Social Security taxes; and Medicare taxes. As required under section 2.b.2 of the Employer Responsibilities on page 4, complete item 5 of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholding.

PRIORITY OF WITHHOLDING

If withholding is required for employee contributions to one or more plans under this notice and for a support obligation under a separate notice and available funds are insufficient for withholding for both cash and medical support contributions, the employer must withhold amounts for purposes of cash support and medical support contributions in accordance with the law, if any, of the State of the employee's principal place of employment requiring prioritization between cash and medical support as described here: deductions to satisfy current support obligations shall have priority over deductions for the employee's share of health insurance premiums which shall have priority over any additional deduction for support arrears authorized by subdivision (g) of section 5241 of NYS Civil Practice Law and Rules.

As required under section 2.b.2 of the Employer Responsibilities on page 4, complete item 5 of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholdings.

The Federal limit applies to the aggregate disposable weekly earnings (ADWE). ADWE is the net income left after making mandatory deductions such as State, Federal, local taxes; Social Security taxes; and Medicare taxes. As required under section 2.b.2 of the Employer Responsibilities on page 4, complete item 5 of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholding.

PRIORITY OF WITHHOLDING

If withholding is required for employee contributions to one or more plans under this notice and for a support obligation under a separate notice and available funds are insufficient for withholding for both cash and medical support contributions, the employer must withhold amounts for purposes of cash support and medical support contributions in accordance with the law, if any, of the State of the employee's principal place of employment requiring prioritization between cash and medical support as described here: deductions to satisfy current support obligations shall have priority over deductions for the employee's share of health insurance premiums which shall have priority over any additional deduction for support arrears authorized by subdivision (g) of section 5241 of NYS Civil Practice Law and Rules.

As required under section 2.b.2 of the Employer Responsibilities on page 4, complete item 5 of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholdings.

- 2. We, the employer, do not offer our employees the option of purchasing dependent or family health care coverage as a benefit of their employment.
- 3. The employee is among a class of employees (for example, part-time or non-union) that are not eligible for family health coverage under any group health plan maintained by the employer or to which the employer contributes. Do not check this box if the employee is only temporarily ineligible for health care coverage.
- 4. Health care coverage is not available because the employee is no longer employed by the employer:

Date of termination: _____

Last known telephone number: _____

Last known address: _____

New employer (if known): _____

New employer telephone number: _____

New employer address: _____

- 5. State or Federal withholding limitations and/or prioritization prevent the withholding from the employee's income of the amount required to obtain coverage under the terms of the plan.
- 6. The participant is subject to a waiting period that expires _____ (more than 90 days from the date of receipt of this Notice), or has not completed a waiting period, which is determined by some measure other than the passage of time, such as the completion of a certain number of hours worked (describe here: _____).

At the completion of the waiting period, the Plan Administrator will process the enrollment.

- 7. Employer forwarded Part B to Plan Administrator on _____



An employer receiving this legal Notice is required to complete and return **Part A**. If group health coverage is not available to the employee named herein, or the employee was never or is no longer employed, the employer is still required to complete **Part A - Employer Response** and return it to the Issuing Agency with the appropriate response checked. If you, the employer, provide the health care benefits to the employee, forward **Part B - Plan Administrator Response** to the health Plan Administrator of your organization. If the employee's health care benefits are administered through another organization, including a labor union, forward **Part B** of the Notice to the labor union or other organization acting as the Plan Administrator for completion. If the employee has already enrolled the child(ren) in health care coverage, the employer must forward **Part B** to the Plan Administrator for completion and submittal to the Issuing Agency.

Keep a copy of **Part A** as it may be used to notify the Issuing Agency if the employee separates from service for any reason including retirement or termination.

EMPLOYER RESPONSIBILITIES

1. If the individual named in this Notice is not your employee, or if family health care coverage is not available, please complete item 1, 2, 3, 4 or 5 of the **Employer Response** as appropriate, and return it to the Issuing Agency. **NO OTHER ACTION IS NECESSARY.**
2. If family health care coverage is available for which the child(ren) identified above may be eligible, you are required to:
 - a. Transfer, not later than 20 business days after the date of this Notice, a copy of **Part B - Medical Support Notice to the Plan Administrator** to the Administrator of each appropriate group health plan for which the child(ren) may be eligible, complete item 7, and
 - b. Upon notification from the Plan Administrator(s) that the child(ren) is/are enrolled, either
 - 1) withhold from the employee's income any employee contributions required under each group health

DURATION OF WITHHOLDING

The child(ren) shall be treated as dependents under the terms of the plan. Coverage of a child as a dependent will end when conditions for eligibility for coverage under the terms of the plan no longer apply. However, the continuation coverage provisions of ERISA may entitle the child to continuation coverage under the plan. The employer must continue to withhold employee contributions and may not disenroll (or eliminate coverage for) the child(ren) unless:

1. The employer is provided satisfactory written evidence that:
 - a. The court or administrative child support order referred to in this Notice is no longer in effect; or
 - b. The child(ren) is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment from the plan; or
2. The employer eliminates family health coverage for all of its employees.

POSSIBLE SANCTIONS

An employer may be subject to sanctions or penalties imposed under State law and/or ERISA for discharging an employee from employment, refusing to employ, or taking disciplinary action against any employee because of medical child support withholding, or for failing to withhold income, or transmit such withheld amounts to the applicable plan(s) as the Notice directs. Sanctions or penalties may be imposed under State law against an employer for failure to respond and/or for non-compliance with this Notice.

NOTICE OF TERMINATION OF EMPLOYMENT

In any case in which the above employee's employment terminates, the employer must promptly notify the Issuing Agency listed above of such termination. This requirement may be satisfied by sending to the Issuing Agency a copy of **Part A** with response 4 checked or any notice the employer is required to provide under the continuation coverage provisions of ERISA or the Health Insurance Portability and Accountability Act. .

EMPLOYEE LIABILITY FOR CONTRIBUTION TO PLAN

The employee is liable for any employee contributions that are required under the plan(s) for enrollment of the child(ren) and is subject to appropriate enforcement. The employee may contest the withholding under this Notice based on a mistake of fact (such as the identity of the obligor). Should an employee contest the withholding under this Notice, the employer must proceed to comply with the employer responsibilities in this Notice until notified by the Issuing Agency to discontinue withholding. To contest the withholding under this Notice, the employee should contact the Issuing Agency at the address and telephone number listed on the Notice. With respect to plans subject to ERISA, it is the view of the Department of Labor that Federal Courts have jurisdiction if the employee challenges a determination that the Notice constitutes a Qualified Medical Child Support Order.

CONTACT FOR QUESTIONS

If you have any questions regarding this Notice, you may contact the Issuing Agency at the address and telephone number listed on page 1 of this Notice.

Medical Support Unit

PO Box 15369

Albany NY 12212-5369

Notice Date: 08/15/2015

CSE Agency Case Identifier: BW21435C1

Telephone Number: 888-208-4485

Fax Number: 518-320-1081

Order Date: 08/12/2015

Order Identifier: F1768614

Document Tracking Identifier: BW21435C1

Employer website: childsupport.ny.gov

See NMSN Instructions:

<http://www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form>



Employer / Withholder's Federal EIN Number

LAKE REGION MEDICAL

Employer / Withholder's Name

3902 CALIFORNIA RD

ORCHARD PARK NY 14127

Employer / Withholder's Address

DURAND, JACLYN M

Custodial Parent's Name (Last, First, MI)

96 WINSPEAR RD

WEST SENECA NY 14224

Custodial Parent's Mailing Address

Child(ren)'s Mailing Address (if different from Custodial Parent's)

Name and Telephone of a Representative of the Child(ren)

RE: DUDEK, DAVID L

Employee's Name (Last, First, MI)

112-80-2406

Employee's Social Security Number

7873 CATHERINE ST

DERBY NY 14047

Employee's Mailing Address

Substituted Official/Agency Name

Substituted Official/Agency Address

(Required if Custodial Parent's mailing address is left blank)

Mailing Address of a Representative of the Child(ren)

Child(ren)'s Name(s)

DUDEK, EMMALYN R

Gender

F

DOB

08/13/2014

SSN

697-37-7968

Rec. No.

01

- b. There is only one type of coverage provided under the plan. The child(ren) is/are included as dependents of the participant under the plan.
- c. The participant is enrolled in an option that is providing dependent coverage and the child(ren) will be enrolled in the same option.
- d. The participant is enrolled in an option that permits dependent coverage that has not been elected; dependent coverage will be provided.

Coverage is effective as of ___ / ___ / ___ (includes waiting period of less than 90 days from date of receipt of this Notice). The child(ren) has/have been enrolled in the following option (if plan is insured, identify provider, policy and group numbers): _____.

Any necessary withholding should commence if the employer determines that it is permitted under State and Federal withholding and/or prioritization limitations.

- 3. There is more than one option available under the plan and the participant is not enrolled. The Issuing Agency must select from the available options. Each child is to be included as a dependent under one of the available options that provide family coverage. If the Issuing Agency does not reply within 20 business days of the date this Response is returned, the child(ren), and the participant if necessary, will be enrolled in the plan's default option, if any: _____.

- 4. The participant is subject to a waiting period that expires ___ / ___ / ___ (more than 90 days from the date of receipt of this Notice), or has not completed a waiting period which is determined by some measure other than the passage of time, such as the completion of a certain number of hours worked (describe here: _____).

At the completion of the waiting period, the plan administrator will process the enrollment.

- 5. This Notice does not constitute a "qualified medical child support order" because:

- The name of the child(ren) or participant is unavailable.

- The mailing address of the child(ren) (or a substituted official) or participant is unavailable.

business days of the date of this Notice, or sooner if reasonable:

(1) Complete **Part B - Plan Administrator Response** - and send it to the Issuing Agency:

(a) if you checked Response 2:

- (i) notify the noncustodial parent/participant named above, each named child, and the custodial parent that coverage of the child(ren) is or will become available (notification of the custodial parent will be deemed notification of the child(ren) if they reside at the same address);
- (ii) furnish the custodial parent a description of the coverage available and the effective date of the coverage, including, if not already provided, a summary plan description and any forms, documents, or information necessary to effectuate such coverage, as well as information necessary to submit claims for benefits;

(b) if you checked Response 3:

- (i) if you have not already done so, provide to the Issuing Agency copies of applicable summary plan descriptions or other documents that describe available coverage including the additional participant contribution necessary to obtain coverage for the child(ren) under each option and whether there is a limited service area for any option;
- (ii) if the plan has a default option, you are to enroll the child(ren) in the default option if you have not received an election from the Issuing Agency within 20 business days of the date you returned the Response. If the plan does not have a default option, you are to enroll the child(ren) in the option selected by the Issuing Agency;

(c) if the participant is subject to a waiting period that expires more than 90 days from the date of receipt of this Notice, or has not completed a waiting period whose duration is determined by a measure other than the passage of time (for example the completion of a certain number of hours

PAYMENT OF CLAIMS

A child covered by a QMCSO, or the child's custodial parent, legal guardian, or the provider of services to the child, or a State agency to the extent assigned the child's rights, may file claims and the plan shall make payment for covered benefits or reimbursement directly to such party.

PERIOD OF COVERAGE

The alternate recipient(s) shall be treated as dependents under the terms of the plan. Coverage of an alternate recipient as a dependent will end when similarly situated dependents are no longer eligible for coverage under the terms of the plan. However, the continuation coverage provisions of ERISA or other applicable law may entitle the alternate recipient to continue coverage under the plan. Once a child is enrolled in the plan as directed above, the alternate recipient may not be disenrolled unless:

- (1) The plan administrator is provided satisfactory written evidence that either:
 - (a) the court or administrative child support order referred to above is no longer in effect, or
 - (b) the alternate recipient is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment from the plan.
- (2) The employer eliminates family health coverage for all of its employees; or
- (3) Any available continuation coverage is not elected, or the period of such coverage expires.

CONTACT FOR QUESTIONS

If you have any questions regarding this Notice, you may contact the Issuing Agency at the address and telephone number listed above.

Dear Plan Administrator:

Please complete this form to provide specific information to verify the enrollment of employee children covered under the group plan. Return this completed form along with **PART B - MEDICAL SUPPORT NOTICE TO PLAN ADMINISTRATOR** to:

ERIE COUNTY SCU
Medical Support Unit
PO Box 15369
Albany NY 12212-5369

EMPLOYEE INFORMATION:

Name: DUDEK, DAVID L
SSN: 112-80-2406
Address:

7873 CATHERINE ST
DERBY NY 14047

EMPLOYER INFORMATION:

Name: LAKE REGION MEDICAL
EIN:
Address:

3902 CALIFORNIA RD
ORCHARD PARK NY 14127

1. The participant is subject to a waiting period that expires* ___/___/___ (more than 90 days from the date of receipt of the Notice), or has not completed a waiting period determined by some measure other than the passage of time, such as the completion of a certain number of hours worked (describe here: _____).

*At the end of the waiting period, the plan administrator must process the enrollment.

2. Indicate by placing a \checkmark in the "yes" or "no" box if the employee's dependent(s) listed is/are enrolled under the group health care coverage plan.

Child(ren)'s Name(s)	Date of Birth	Social Security Number	Record No.	YES	NO
DUDEK, EMMALYN R	08/13/2014	697-37-7968	01	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

Code(s)																								
Group Ins. Carrier #1: _____															NYS INS CD _____									
Claims address: _____																								
Policyholder ID No. _____															Group No. _____					Effective Date: / /				

Code(s)																								
Group Ins. Carrier #2: _____															NYS INS CD _____									
Claims address: _____																								
Policyholder ID No. _____															Group No. _____					Effective Date: / /				

Code(s)																								
Group Ins. Carrier #3: _____															NYS INS CD _____									
Claims address: _____																								
Policyholder ID No. _____															Group No. _____					Effective Date: / /				

Code(s)																								
Group Ins. Carrier #4: _____															NYS INS CD _____									
Claims address: _____																								
Policyholder ID No. _____															Group No. _____					Effective Date: / /				

Code:																								
Group Ins. Carrier #5: _____															NYS INS CD _____									
Claims address: _____																								
Policyholder ID No. _____															Group No. _____					Effective Date: / /				

COVERAGE CODES

CL	Clinic	ER	Emergency Room	PO	Physician in-office
CM	Complement to Medicare	HH	Home Health	PI	Psychiatric in-patient
DN	Dental	IP	In-Patient	PS	Psychiatric out-patient
DM	Drugs (Major Medical)	MM	Major Medical	SI	Substance abuse in-patient
DR	Drugs (no card provided)	NH	Nursing Home	SO	Substance abuse out-patient
DC	Drugs (with co-pay)	OP	Optical	TR	Transportation
EQ	Durable medical equipment	PH	Physician in-hospital		

Completed By: _____
 Phone Number: _____

Title: _____
 Date: _____

New York Case Identifier: BW21435C1	County Code: 14	JRE No: 07	Worker Code: EN07
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