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 have policies to enforce against custodial parents.

[X] **National Medical Support Order / Notice (NMSN)** [ ] **Termination Order/Notice – if checked, see page 2**

Notice Date: 05/19/2025

Issuing Agency: STATE OF WASHINGTON
DIVISION OF CHILD SUPPORT

Address: PO BOX 11520
TACOMA WA 98411-5520

Case Identifier: 2812389

Telephone Number: (800) 729-7580

Email Address:

Fax Number: (866) 668-9518

Court or Administrative Authority:

Order Date: 3/4/2020

Order Identifier: ADM0002812389-0001

Document Tracking Identifier:

Employer website: https://www.dshs.wa.gov/esa/faq

See NMSN Instructions:
https://www.acf.hhs.gov/sites/default/files/documents/ocse/omb_0970-0222_a_instructions.pdf

814321846
Employer/Withholder's Federal EIN Number

BEACON HILL, INC.
Employer/Withholder's Name

5195 ROAD 9 NW
EPHRATA WA 98823
Employer/Withholder's Address

LOPEZ LARA ARACELI
Custodial Parent's Name (Last, First, MI)

ARACELI LOPEZ LARA
19097 RD 9 NW APT 9
QUINCY WA 98848-9433
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: BENICIO BELTRAN EDEN
Employee's Name (Last, First, MI)

531-29-5932
Employee's Social Security Number

102 B ST NE
QUINCY WA 98848
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
BENICIO LOPEZ	CAMILA	F	3/27/2011	536-71-6380

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

EMPLOYER RESPONSE

Section 1 – No Enrollment Possible

The employer knows that the plan administrator cannot enroll dependents in employer-provided health care coverage for the employee named on page 1, because: (select all that apply)

☐ 1. The employee named in this Notice has never been employed by this employer.

☐ 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 care coverage under any group health care plan maintained by the employer or to which the employer contributes. **If the employee is only temporarily ineligible for health care coverage, do not check this box, and advance to Section 2.**

☐ 4. Health care coverage is not available because employee is no longer employed here:

Effective date of separation: _____

Reason for separation: _____

Last known telephone number: _____

Last known address: _____

(If new employment information is known, add at #6).

☐ 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. (See page 2 for description and instructions.)

☐ 6. Other (new job information for employee, child adequately covered by 3rd party, other reason for no coverage):

_____ .

Section 2 – Dependent Enrollment Not Yet Available

☐ 7. 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.

☐ 8. Employee is on an unpaid leave of absence. Expected date of return: _____

Section 3 – Dependent Coverage Available

☐ 9. Employer forwarded Part B -Medical Support Notice to Plan Administrator on this date: _____

COMPLETED BY:

Employer Company Name	Plan Administrator Company / Union Name
BEACON HILL, INC.	
Contact Name:	Contact Name:
Title:	Title:
Email:	Email:
Telephone:	Telephone:
FAX:	FAX:
FEIN:	FEIN:

2. If the Termination Order/Notice checkbox is checked, you are required to terminate the NMSN/ Qualified Medical Child Support Order (QMCSO) and health care coverage for the child(ren) identified in the order **unless the employee has indicated that they want to continue coverage voluntarily.** If this employeeis also under a wage withholding order for payment of child support, release of this health care insurance order may result in an increase in the amount of earnings available to remit to the state disbursement unit as child support. Release of this health care insurance order does not negate your obligation to comply with wage withholding and/or other health care insurance orders for this employee.

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 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 care coverage for all of its employees; or
3. Any available continuation coverage is not elected, or the period of such coverage expires.

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 - Notice to Withhold for Health Care Coverage**, with Section 1, item 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 page 1 of this 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.

For Frequently Asked Questions (FAQs) about the NMSN, see Resource Library | The Administration for Children and Families (hhs.gov) https://www.acf.hhs.gov/css/resource-library

Washington State Department of Social & Health Services
Transforming lives

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
DIVISION OF CHILD SUPPORT (DCS)

Cover Letter for the National Medical Support Notice - Part B - Medical Support Notice to Plan Administrator

This Notice Contains Confidential Information: Employer, employee, child, and custodial parent address information contained in Part B of the ***National Medical Support Notice*** is confidential. **Do not** give address information or a copy of the first page of the form to the employee, custodial parent, or family member, relative, or friend of either party.

1. NOTE: Letter C in the Instructions to Plan Administrator states, "Any required notification of the custodial parent, children and / or participant may be satisfied by sending the party a copy of the Plan Administrator Response, if appropriate."
2. If the Plan Administrator sends a party, other than the Issuing Agency, a copy of the **Plan Administrator Response**, the Plan Administrator **must not** send the party a copy of the first page of the ***Medical Support Notice to Plan Administrator.***

For federal audit purposes, the Division of Child Support (DCS) must have the employee's insurance information in the DCS case files. DCS must send the insurance information to the Medicaid Agency when the employee's child receives Medicaid. DCS needs the insurance information specified in the attached ***Washington State Addendum to Box 2 of Part B - Plan Administrator Response.***

- If you mark **box 2** on the **Plan Administrator Response** form, please complete the Addendum and return it to DCS with your Response. In lieu of completing the form, you may attach any preprinted information that provides the name, address, telephone numbers, policy numbers, and group numbers for claims submission.

Information regarding the health insurance premium costs:

1. When the **employee is already enrolled** in a health insurance plan and the employer or plan administrator adds only the children, then only the children's portion of the health insurance premium applies to the Consumer Credit Protection Act (CCPA) limitation on withholding for cash and medical support.
2. When the **employee is not already enrolled** in a health insurance plan and must be enrolled in order to enroll the children, then both the employee's and children's health insurance premium applies to the CCPA limitation on withholding for cash and medical support.
3. Use the premium amount limits marked below to determine if you have to enroll the eligible children listed on the ***National Medical Support Notice*** in an available health insurance plan. If there are multiple ***National Medical Support Notice*** forms for the employee, please add the insurance premium amounts for the notices to determine the total premium amount limit. Enroll the children in the least expensive plan that provides the children coverage. The premium amount listed here applies only to an additional cost to add the children to the plan. It does not include the cost the employee has to pay for employee coverage only.
   a. ☐ Enroll the children only if you can do so at no cost to the employee.
   b. ☐ Enroll the children only if you pay all or part of the premium to cover the children.
   c. ☒ Enroll the children only if the employee's premium (to cover the children only) is not more than $ 68.00 each month. If the premium exceeds this amount, you do not have to enroll the children.
   d. ☐ There is no set limit for the employee's premium amount (to cover the children only).

For more information, visit the DCS website at: https://www.dshs.wa.gov/esa/division-child-support/medical-support

NATIONAL MEDICAL SUPPORT NOTICE - PART B
MEDICAL SUPPORT NOTICE TO PLAN ADMINISTRATOR

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 (CSPIA). Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable law. The rights of the parties and the duties of the plan administrator under this Notice are in addition to the existing rights and duties established under such 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 have policies to enforce against the custodial parent.

Notice Date: 05/19/2025

Issuing Agency: STATE OF WASHINGTON
DIVISION OF CHILD SUPPORT

Address: PO BOX 11520
TACOMA WA 98411-5520

Case Identifier: 2812389

Telephone Number: (800) 729-7580

Email Address:

FAX Number: (866) 668-9518

Court or Administrative Authority:

Order Date: 3/4/2020

Order Identifier: ADM0002812389-0001

Document Tracking Identifier:

Employer website: https://www.dshs.wa.gov/esa/faq

See NMSN Instructions:http://www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form

814321846
Employer/Withholder's Federal EIN Number

BEACON HILL, INC.
Employer/Withholder's Name

5195 ROAD 9 NW
EPHRATA WA 98823
Employer/Withholder's Address

LOPEZ LARA ARACELI
Custodial Parent's Name (Last, First, MI)

ARACELI LOPEZ LARA
19097 RD 9 NW APT 9
QUINCY WA 98848-9433
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: BENICIO BELTRAN EDEN
Employee's Name (Last, First, MI)

531-29-5932
Employee's Social Security Number

102 B ST NE
QUINCY WA 98848
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
BENICIO LOPEZ	CAMILA	F	3/27/2011	536-71-6380

The order requires the child(ren) to be enrolled in X 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) No persons are required to respond to a collection of information unlessit displays a valid OMB control number. The time required to complete this information collection is estimate to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete the review of the information collection. **OMB control number: 1210-0113 Expiration Date:**

INSTRUCTIONS TO PLAN ADMINISTRATOR

This Notice has been forwarded from the employer identified above to you as the plan administrator of a group health plan maintained by the employer (or a group health plan to which the employer contributes) and in which the noncustodial parent/participant identified above is enrolled or is eligible for enrollment.

This Notice serves to inform you that the noncustodial parent/participant is obligated by an order issued by the court or agency identified above to provide health care coverage for the child(ren) under the group health plan(s) as described on **Part B**.

(A) If the participant and child(ren) and their mailing addresses (or that of a Substituted Official or Agency) are identified above, and if coverage for the child(ren) is or will become available, this Notice constitutes a "qualified medical child support order" (QMCSO) under ERISA or CSPIA, as applicable. (If any mailing address is not present, but it is reasonably accessible, this Notice will not fail to be a QMCSO on that basis.) You must, within 40 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, complete Addendum Section 1 and:

(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); and

(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. You must complete Addendum Section I.

(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 worked), complete Response 4 on the Plan Administrator Response and return to the employer and the Issuing Agency, and notify the participant and the custodial parent; and upon satisfaction of the period or requirement, complete enrollment under Response 2 or 3, and

(d) upon completion of the enrollment, transfer the applicable information on Part B -Plan Administrator Response to the employer for a determination that the necessary employee contributions are available. Inform the employer that the enrollment is pursuant to a National Medical Support Notice.

(B) If within 40 business days of the date of this Notice, or sooner if reasonable, you determine that this Notice does not constitute a QMCSO, you must complete Response 5 of Part B -Plan Administrator Response and send it to the Issuing Agency, and inform the noncustodial parent/participant, custodial parent, and child(ren) of the specific reasons for your determination. Identify child(ren) at or above the age at which dependents are no longer eligible for coverage under the plan in Addendum Section 2.

(C) Any required notification of the custodial parent, child(ren) and/or participant may be satisfied by sending the party a copy of the Plan Administrator Response, if appropriate. You may choose to furnish these notifications electronically in accordance with the requirements of the Department of Labor's electronic disclosure regulation codified at 29 C.F.R. 2520.104b-1(c).

NATIONAL MEDICAL SUPPORT NOTICE – ADDENDUM TO PART B

Notice Date: 05/19/2025	Court or Administrative Authority:
Issuing Agency: STATE OF WASHINGTON DIVISION OF CHILD SUPPORT	
Address: PO BOX 11520 TACOMA WA 98411-5520	Order Date: 3/4/2020
Case Identifier: 2812389	Order Identifier: ADM0002812389-0001
Telephone Number: (800) 729-7580	Document Tracking Identifier:
Email Address:	Employer Web Site: https://www.dshs.wa.gov/esa/faq
FAX Number: (866) 668-9518	See NMSN Instructions:http://www.acf.hhs.gov/programs/css/resource/national-medical-support-notice-form

SECTION 1: HEALTH INSURANCE DETAILS

Use section 1-1 through 1-6 to provide the information on the plans in which child (ren) is/are enrolled. Complete all of the following information for each type of health care coverage that the child(ren) is receiving (enrolled in) and attach this document to the completed PLAN ADMINISTRATOR RESPONSE.

SECTION 1-1: MEDICAL INSURANCE **Effective Date of Coverage:** _____

Insurance Provider Name | Group Number | Policy Number

Insurance Provider Claims Address Line 1 | Insurance Provider Claims Address Line 2

Insurance Provider Claims City | State | Zip Code | Phone Number for Claims

Medical Insurance Coverage Also Includes: (Check all that apply)

☐ Dental; ☐ Vision; ☐ Prescription drug; ☐ Mental health; ☐ Other (specify): _____

SECTION 1-2: DENTAL INSURANCE **Effective Date of Coverage:** _____

Insurance Provider Name | Group Number | Policy Number

Insurance Provider Claims Address Line 1 | Insurance Provider Claims Address Line 2

Insurance Provider Claims City | State | Zip Code | Phone Number for Claims

SECTION 1-3: VISION INSURANCE **Effective Date of Coverage:** _____

Insurance Provider Name | Group Number | Policy Number

Insurance Provider Claims Address Line 1 | Insurance Provider Claims Address Line 2

Insurance Provider Claims City | State | Zip Code | Phone Number for Claims

Washington State Department of Social & Health Services
DCS Division of Child Support

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
DIVISION OF CHILD SUPPORT (DCS)

Washington State Addendum to Box 2 of Part B - Plan Administrator Response

TO: PO Box 11520
Tacoma WA 98411-5520

RE: EDEN BENICIO BELTRAN

SSN: 531-29-5932

IV-D CASE NUMBER: 2812389

EMPLOYER: BEACON HILL, INC.

FROM: _____ (Name of Plan Administrator or Employer Representative)

The children listed in ***Part B, Medical Support Notice to Plan Administrator*** are enrolled in the following plan(s). Send all claims to the names and addresses provided below.

HEALTH INSURANCE PLAN	
COMPANY NAME AND ADDRESS	POLICY NUMBER:
	GROUP NUMBER:
	TELEPHONE NUMBER:
	EFFECTIVE DATE:

DENTAL INSURANCE PLAN	
COMPANY NAME AND ADDRESS	POLICY NUMBER:
	GROUP NUMBER:
	TELEPHONE NUMBER:
	EFFECTIVE DATE:

PRESCRIPTION DRUG INSURANCE PLAN	
COMPANY NAME AND ADDRESS	POLICY NUMBER:
	GROUP NUMBER:
	TELEPHONE NUMBER:
	EFFECTIVE DATE:

VISION INSURANCE PLAN	
COMPANY NAME AND ADDRESS	POLICY NUMBER:
	GROUP NUMBER:
	TELEPHONE NUMBER:
	EFFECTIVE DATE:

Amount of monthly premium required to cover the children: $ _____

Check the applicable box below.

ID cards/benefit information:
- ☐ Will be sent to the children's custodian.
- ☐ Will be sent to the Division of Child Support.
- ☐ Will not be sent.

Washington State
Department of Social
& Health Services

Transforming lives

BEACON HILL INC.
5195 ROAD 9 NW
EPHRATA WA 98823

Enclosed are form(s) that need appropriate action taken. If you need to contact the Child Support Office that is handling this case, please provide the following number: 2812389

Please visit our website childsupportonline.wa.gov for additional information.

FG VER: (1.8)
4478:05192025/
2812389 / 1688

Washington State Department of Social & Health Services
Transforming lives

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
DIVISION OF CHILD SUPPORT (DCS)

Cover Letter for the National Medical Support Notice - Part A - Notice to Withhold for Health Care Coverage

This Notice Contains Confidential Information: Employer, employee, child, and custodial parent address information contained in Part A and Part B of the ***National Medical Support Notice*** is confidential. **Do not** give address information or a copy of the first pages of Part A or Part B to the employee, custodial parent, or family member, relative, or friend of either party.

Please be sure to send the Part B Cover letter and the ***Washington State Addendum to Box 2 of Part B - Plan Administrator Response*** to the appropriate plan administrator(s) with Part B.

If the employee's health / dental insurance coverage is available through a union, forward Part B to the union's third party administrator.

If the employee has multiple cases requiring health care coverage, the Division of Child Support (DCS) enclosed a separate ***National Medical Support Notice*** for each case. Be sure to send Part B of all of the notices to the plan administrator.

Additional information regarding limitations on withholding:

1. When the employee's principal place of employment is in Washington State, the total amount withheld for both child support and the children's health insurance premium cannot exceed 50 percent of the employee's disposable earnings.
   a. When the **employee is already enrolled** in a health insurance plan and the employer or plan administrator adds only the children, then only the children's portion of the health insurance premium applies to the above limitation on withholding.
   b. When the **employee is not already enrolled** in a health insurance plan and must be enrolled in order to enroll the children, then both the employee and children's health insurance premium applies to the above limitation on withholding.
2. Use the premium amount limits marked below to determine if you have to enroll the eligible children listed on the ***National Medical Support Notice*** in an available health insurance plan. If there are multiple ***National Medical Support Notice*** forms for the employee, please add the insurance premium amounts for the notices to determine the total premium amount limit. Enroll the children in the least expensive plan that provides the children coverage. The premium amount listed here and in the ***National Medical Support Notice*** applies only to an additional cost to add the children to the plan. It does not include the cost the employee has to pay for employee coverage only.
   a. ☐ Enroll the children only if you can do so at no cost to the employee.
   b. ☐ Enroll the children only if you pay all or part of the premium to cover the children.
   c. ☒ Enroll the children only if the employee's premium (to cover the children only) is not more than $ 68.00 each month. If the premium exceeds this amount, you do not have to enroll the children.
   d. ☐ There is no set limit for the employee's premium amount (to cover the children only).

If the cost of the children's coverage is more than the limit shown above, mark **box 5** and state the cost of the premium on the Employer Response page of the ***National Medical Support Notice***. (Example: Premium cost is $ _____.)

For more information, visit our website at: https://www.dshs.wa.gov/esa/division-child-support