

**FERRIS STATE UNIVERSITY
HEALTH PLAN
SUPPLEMENTAL INFORMATION**

Non-Bargaining Unit Employees

- **Administrative**
- **Administrative Support**
- **Temporary Administrative Support**
- **Temporary Faculty**

Effective July 1, 2005

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This document, together with the Benefits Guide and any other documents provided to you by Blue Cross Blue Shield of Michigan constitute the plan document and Summary Plan Description for your coverage. This document does not create a contract of employment.

GENERAL PLAN INFORMATION

PLAN NAME

FERRIS STATE UNIVERSITY HEALTH PLAN
for Non-Bargaining Unit Employees

- Administrative
- Administrative Support
- Temporary Administrative Support
- Temporary Faculty

EMPLOYER AND PLAN ADMINISTRATOR

Ferris State University
Prakken 150
420 Oak Street
Big Rapids, Michigan 49307
(231)591-2150

EMPLOYER IDENTIFICATION NUMBER

38-6005159

PLAN YEAR

July 1 – June 30 (Plan deductibles and out-of-pocket maximum limits are based on the calendar year.)

TYPE OF PLAN

Group Health Plan

FUNDING

Group health benefits under this Plan are self-insured by the University. Benefits are not provided through insurance but are paid by the University from its general assets. Claims are processed by a third-party administrator.

The cost of coverage is shared by the University and covered employees. The University maintains a Section 125 Plan that permits employee contributions to be paid on a pre-tax basis. Each year the University determines the amount of employee premium contributions for each coverage option under the Plan.

CLAIMS ADMINISTRATOR

The University has entered into a contract with a claims administrator to process claims and provide administrative services for the Plan. The name and address of the claims administrator is:

Blue Cross Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226-2998
1-800-972-9797 (Grand Rapids Customer Service Department)

ELIGIBILITY AND PARTICIPATION

EMPLOYEE ELIGIBILITY

The following non-union employees are eligible for coverage under this Plan:

- All Administrative and Administrative Support Employees who are hired on a full-time assignment and scheduled to work at least 20 hours per week.
- All Administrative and Administrative Support Employees who are hired on a full-time temporary or grant-funded assignment, are scheduled to work at least 40 hours per week and are not classified as student employees.
- Full-time Temporary Faculty hired for a full academic year or more are eligible for coverage in accordance with the terms of their employment contracts.

Except as specifically listed above, leased, part-time, seasonal, temporary and on-call employees, and interns are not eligible for coverage.

DEPENDENT ELIGIBILITY

Dependent (including spouse) eligibility requirements are set forth in the Blue Cross Blue Shield Benefits Guide.

EFFECTIVE DATE OF COVERAGE

Coverage will be effective on the Effective Date of the Plan for an employee who has met the eligibility requirements and has properly enrolled in the Plan.

For new employees, coverage begins on the first day of the month after employment begins, provided the employee has properly enrolled (see New Employee Enrollment below).

Coverage for eligible dependents generally begins when the employee's does, or when the dependent first becomes eligible, as long as the employee has completed and timely filed the required enrollment form.

ENROLLMENT

NEW EMPLOYEE ENROLLMENT

You must enroll for coverage within 30 days after your employment begins. To cover eligible dependents, including newborn and newly adopted children and children placed with you for adoption, you must enroll them in the Plan as well. If you elect dependent coverage, you and your dependents must be enrolled in the same coverage option. If your spouse is also an employee of University who is eligible for coverage, you and your spouse may each elect individual coverage, or one of you may elect coverage for both while the other spouse waives coverage.

If an application for coverage is made after the first date on which coverage could begin, but within 30 days after that date, coverage will be retroactive to the first date on which coverage could have begun. If an application for coverage is made more than 30 days after the first date on which coverage could begin, but within 60 days after that date, coverage will begin on the first of the month following the date of application.

If an application for coverage is not made within 60 days after the date coverage could have begun, the applicant must wait until the annual open enrollment period unless the applicant has special enrollment rights to enroll during a special enrollment period described below.

OPEN ENROLLMENT PERIOD

The University will conduct an open enrollment period near the end of each plan year. An eligible employee may enroll for coverage and may also enroll any eligible dependents or may change coverage options during the annual open enrollment period.

SPECIAL ENROLLMENT RIGHTS

A “special enrollment period” is a period of enrollment (other than the open enrollment period or an enrollment period for new employees) during which an individual with special enrollment rights may elect to enroll in this plan. An employee and his or her eligible dependents may enroll during a special enrollment period in the following situations:

Enrollment Of Newly Eligible Dependents

If an eligible employee gains a new dependent as a result of marriage, birth, adoption, or placement for adoption, the following individuals may be enrolled in the plan if they are not currently enrolled: (1) the employee; (2) the employee’s spouse; and (3) any new dependents. The Plan will extend group health benefits to dependent children who are adopted by, or placed for adoption with, you under the same terms and conditions as for other dependent children. The employee must file a completed enrollment form within 30 days after the marriage, birth, adoption, or placement for adoption. Coverage will be effective on the date of the marriage, birth, adoption, or placement for adoption.

The employee must complete a request to enroll a newborn child, newly adopted child or child placed for adoption for coverage under the Plan within 30 days after the child is born, adopted or placed for adoption.

Loss Of Other Coverage

If you or your dependents are eligible for coverage under this Plan but did not enroll because you were covered under another group health plan or had other health insurance coverage, you may be eligible to enroll in the Plan during a special enrollment period if you lose that other coverage. The following individuals may enroll in the Plan if they are not currently enrolled: (1) the employee; (2) the employee’s spouse; and (3) any other eligible dependents provided the following requirements are met:

- You declined coverage (in writing, if the plan required a written statement) when it was previously offered because you or your dependents were covered under another group health plan or had other health insurance coverage;
- The other coverage was COBRA continuation and it ran out or the other coverage was not COBRA continuation coverage and it ended because you lost eligibility (including as a result of divorce, legal separation, loss of dependent status, death, termination or reduction in hours of employment, or because you no longer live or work in the other health plan's service area, the other plan no longer offers any benefits to a class of similarly situated individuals, your claims have exceeded the lifetime benefit limit or because the employer stopped making contributions);

- You must request enrollment within 30 days after the other coverage ended (or 30 days after a claim is denied due to the lifetime benefit limit). If a certificate of creditable coverage is not provided before the date the other coverage ends, you must request enrollment within 30 days after the Certificate of Creditable Coverage is provided but not later than 44 days after the other coverage ends; and
- You must provide proof of loss of other coverage that is acceptable to the Plan Administrator.

An individual who loses coverage for any of the following reasons is not eligible for special enrollment:

- The individual did not pay premiums on a timely basis.
- The individual voluntarily dropped coverage for any reason, including an increase in premium or change in benefits.
- The coverage was terminated for cause, such as for making a fraudulent claim or giving false information.

Enrollment due to loss of other coverage will be effective on the first day following the loss of other coverage.

LATE ENROLLMENT

If you did not enroll when first eligible under this Plan and you do not meet the requirements for a special enrollment period, you must wait to enroll during an open enrollment period. You will be considered a "late enrollee" for purposes of any pre-existing condition limitation described in the Benefits Guide.

CERTIFICATE OF CREDITABLE COVERAGE

You and your covered dependent(s) will automatically receive a "certificate of creditable coverage" when your coverage terminates under this Plan or when any COBRA continuation coverage terminates. The certificate will provide evidence of the coverage you had under this Plan. If you become covered by another health plan or health insurance, the certificate may help you obtain the new coverage without a pre-existing condition exclusion or with a shorter exclusion period.

You and your covered dependent(s) have the right to request a certificate of creditable coverage at any time that you are covered under this Plan and for 24 months after your coverage terminates. To request a certificate of creditable coverage, contact the University's Office of Human Resources in writing at Prakken 150, 420 Oak Street, Big Rapids, Michigan 49307 or by telephone at 231-591-2150.

TERMINATION OF COVERAGE

EMPLOYEE TERMINATION

Employee coverage terminates upon the earliest of the following dates, except as provided in the Continuation of Coverage provisions:

- End of the month in which employment terminates;
- End of the month in which the Employee goes on an unpaid leave of absence (other than FMLA leave) or is actively at work for less than the number of hours per week required for coverage. A reduction in hours due to leave under the FMLA shall not cause health coverage to end (see "Continuation of Coverage under the Family and Medical Leave Act");
- End of the month in which the Employee ceases to be in an eligible coverage classification;
- End of the month prior to the month for which an Employee fails to timely make a required contribution for coverage;
- Date the Plan is terminated; or with respect to any benefits of the Plan, the date of termination of such benefits;
- Date the Plan Administrator terminates the Employee's coverage for cause, e.g., fraud or misrepresentation in enrollment or a claim for benefits; or
- Effective date of the Employee's notice of voluntary withdrawal.

DEPENDENT TERMINATION

Dependent Coverage terminates upon the earliest of the following dates, except as provided in the Continuation of Coverage provisions:

- Date an individual ceases to be a Dependent (unless he or she qualifies for dependent continuation coverage for individuals between ages 19 and 25 as described in the Benefits Guide, in which case coverage continues until the end of the year in which the individual turns age 25);
- Date of termination of the Employee's coverage under the Plan;
- Date the Plan Administrator terminates the Dependent's coverage for cause, e.g., fraud or misrepresentation in an application for enrollment or a claim for benefits;
- Date the Dependent begins coverage as an employee under the Plan; or
- Effective Date of the Dependent's notice of voluntary withdrawal.

PLAN BENEFITS

To give you flexibility in meeting your health coverage needs, the Ferris State University Health Plan provides you a choice among three different health plan coverage options:

- Community Blue PPO – No Deductible
- Community Blue PPO – \$250/\$500 In-Network Deductible
- Community Blue PPO – \$1,000/\$2,000 In-Network Deductible

The Blue Cross Blue Shield Benefits Guide describes in detail the benefits provided by the coverage option you have selected. The Benefits Guide will include the following information to the extent it applies to the option you have selected:

- A detailed schedule of benefits and cost-sharing provisions
- Any annual or lifetime caps or other limits on benefits
- The extent to which preventive services are covered
- Whether (and under what circumstances) existing and new drugs are covered
- Details of coverage for medical tests, devices and procedures
- Provisions regarding the use of network providers
- Circumstances under which coverage is provided for out of network services
- Conditions or limits on the selection of primary care providers
- Conditions or limits on the selection of providers of specialty medical care
- Conditions or limits applicable to obtaining emergency care
- Requirements for pre-authorization and utilization review
- Circumstances which may result in your (or a covered dependent's) disqualification or ineligibility under the Plan, or in the denial, loss, forfeiture, suspension, offset, reduction, or recovery (e.g., by subrogation or reimbursement rights) of any benefits that you or your covered dependent might otherwise expect to receive under the Plan.

CONTINUATION OF COVERAGE

COBRA CONTINUATION COVERAGE

You and/or your covered dependents may elect to continue coverage under this Plan when coverage would otherwise end because of certain qualifying events.

Employee/Dependents

You and your covered dependents may elect to continue group health coverage for up to 18 months if you lose coverage due to a change in your employment status

from full-time to part-time or if your employment ends for any reason except gross misconduct. This coverage may extend an additional 11 months (up to 29 months total) if you or a covered family are determined to be “disabled” for Social Security purposes at any time within the first 60 days of COBRA coverage.

Dependents Only

Your spouse and/or dependent children may elect to continue their coverage for up to 36 months if their coverage would otherwise end because:

- you die;
- you become entitled to Medicare
- you become legally separated or divorced from your spouse; or
- your dependent children cease to qualify as eligible dependents under the plan

Cost of Continuation Coverage

The continued coverage, if elected, will be the same coverage you had immediately before the qualifying event. You or your eligible dependents must pay the entire cost of this coverage. The cost will be 102% of the University’s cost (150% of the University’s cost during the 11-month disability extension period if the disabled individual is included in the coverage group). If coverage changes for active employees, COBRA coverage will also change, and your premium will be adjusted accordingly.

Early Termination of Continuation Coverage

Continuation coverage will terminate before the end of the 18, 29 or 36-month period as follows: (i) for any person who becomes covered under any other group health plan (as an employee or otherwise) after the COBRA election unless the other plan limits or excludes coverage for a pre-existing condition and the limitation or exclusion applies despite the crediting of prior coverage under the Health Insurance Portability and Accountability Act of 1996; (ii) for any person who becomes entitled to Medicare benefits after the COBRA election; (iii) if the monthly premium is not timely paid (within 45 days for initial premium; within 30 days of the due date for monthly premium payments); (iv) if the company terminates all of its group health plans; or (v) for any reason that otherwise permits termination of coverage for cause under the plan(s) (such as submission of a fraudulent claim).

Your Duty to Notify

Qualifying Event

To be eligible for COBRA coverage, it is your or your dependent's responsibility to notify the Plan Administrator within 60 days after legal separation, divorce or your child's loss of dependent status or, if later, within 60 days after coverage is lost because of such an event. The notice must be in writing and identify the type of qualifying event and the date it occurred.

Second Qualifying Event

If your dependents are already receiving COBRA coverage because of an 18-month qualifying event, a second qualifying event may entitle them to extend COBRA coverage to a total of 36 months (if the second event would have caused a loss of coverage had the first event not occurred). If a second qualifying event takes place within the initial 18-month COBRA continuation coverage period, you or your dependents must notify the Plan Administrator in writing within 60 days after the event, identifying the qualifying event and the date it occurred. Otherwise an extension of COBRA coverage will not be available.

Disability Extension

In order to trigger the 11-month disability extension, you must notify the Plan Administrator of a disability determination in writing, together with a copy of the Social Security determination, no later than 60 days after the latest of (i) the date of the Social Security determination, (ii) the date of the qualifying event, or (iii) the date coverage was lost because of the qualifying event. In any case, the notice must be provided before the end of the first 18 months of COBRA coverage. Also, if the Social Security Administration determines that the disability has ended before the end of COBRA extension coverage, you must notify the Plan Administrator in writing of that fact within 30 days and the extended COBRA coverage will end.

All notices required by this Section should be addressed to the Plan Administrator at the address shown under "General Plan Information."

CONTINUATION FOR MILITARY SERVICE (USERRA)

If you are an Employee absent from work because of military service, you may elect to continue coverage under this Plan for yourself and dependents for up to 24 months or, if earlier, until the day after you are required to apply for or return to reemployment under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

To be eligible for this continued coverage, you (or an appropriate officer of the uniformed service branch in which you will serve) must notify the Plan Administrator that you intend to leave work to serve in the military. In most cases, you must provide notice to the Plan Administrator at least 30 days before you leave for military service. However, you are excused from providing prior notice of your upcoming military leave if military necessity prevents you from providing notice, or if it is otherwise impossible or unreasonable under the circumstances for you to do so.

If you decide to continue your coverage under the Plan, you must elect continued coverage within 60 days from your last day of work before you left due to military service. Your election notice must be given in writing to the Plan Administrator.

Your premium will be the same as for a COBRA beneficiary, except that if you are absent for less than 31 days, the employee contribution will be the same as for similarly situated active employees. Your first payment must be made within 45 days from the date you elected to continue coverage. After the initial premium, you must make monthly premium payments within 30 days of the due date. Your continuation coverage will terminate if the monthly premium is not timely paid.

Whether or not you elect to continue coverage during your period of service, you may reinstate coverage under this Plan when you return to work from military service as required under the USERRA. Coverage will be reinstated without regard to any pre-existing condition exclusion or waiting period except as would have applied if your coverage had not terminated because of military service. This waiver of exclusions and waiting periods will not apply to any illness or injury that the Plan Administrator determines was incurred in, or aggravated during, the performance of military service.

CONTINUATION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

An employee on leave under the Family and Medical Leave Act of 1993 ("FMLA") may continue coverage under this Plan during the leave on the same basis as if he or she had been actively at work during FMLA leave. Coverage will end on the last day of the month in which the employee fails to return from the FMLA leave for any reason other than the continuation, recurrence, or onset of a "serious health condition" (as defined in the FMLA) or any other circumstance determined by the Plan Administrator to be beyond the control of the employee, and the University may recover from the employee any amount it paid to maintain coverage for the employee and covered dependents during the FMLA leave. Other provisions regarding FMLA leave are described in the University's FMLA policy.

CONTINUATION IF YOU ARE DISABLED OR ON WORKERS COMPENSATION

For Disability: If you are classified as a full-time continuing (not temporary) administrative or administrative support employee and you become totally disabled as defined by the University's long-term disability policy, your coverage will be continued under this Plan for yourself and your eligible dependents for up to two (2) years from the date you ceased active work. This two-year extension is not available to employees classified as Temporary.

For Workers Compensation: If you are disabled due to an illness or injury for which you are receiving workers compensation or benefits under any other similar occupational or employer liability statute, you may continue coverage under this Plan for yourself and your eligible dependents for one (1) year from the date you ceased active work or, if earlier, the date your employment would otherwise have ended.

For Both Disability and Workers Compensation: Your contribution for this coverage will be the same as for an active employee, and your coverage will be the same as that in effect on the day before your disability began, subject to any changes applicable to active employees. Benefits will not be paid, however, for any charges covered by workers compensation or other similar occupational or employer liability statute.

Coverage under this Plan during disability or workers compensation leave will be counted toward the maximum COBRA continuation coverage period.

HOW THE PLAN IS ADMINISTERED

The University is the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out in accordance with its terms for the exclusive benefit of participants and beneficiaries. The administrative duties of the Plan Administrator include, but are not limited to, prescribing applicable plan administration procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments. The Plan Administrator has the discretionary authority to interpret the Plan, to make eligibility and benefit determinations and to make factual determinations as to whether an individual is entitled to receive benefits under the Plan.

The Plan Administrator has delegated the responsibility for processing claims and determining the amount of benefits payable under the Plan to the Claims Administrator listed under General Plan Information.

CLAIMS AND APPEALS

To obtain benefits under this Plan, you must follow the claims procedures in the Benefits Guide. Information on the time frame for claims decision and the procedures to follow for the appeal of denied claims are also contained in the Blue Cross Blue Shield Benefits Guide.

PLAN AMENDMENT AND TERMINATION

The University has the right to amend or terminate this Plan or any of the benefits under the Plan and to modify any contributions required for coverage, at any time. No consent of any participant is required. You will be notified of the termination or any material modification of this Plan. No plan amendment or termination will affect any claim for covered expenses incurred by you prior to the amendment or termination.

HIPAA PRIVACY PROTECTION

This section is intended to comply with the Health Insurance Portability and Accountability Act (“HIPAA”) privacy rules found at 45 CFR Parts 160 and 164 (“Privacy Rules”). All definitions in the Privacy Rules are incorporated by reference into this section of the Plan. If a term is not defined in the Privacy Rules, the term will have its generally accepted meaning.

PROTECTED HEALTH INFORMATION (“PHI”)

The Plan will have access to protected health information (“PHI”) only as permitted under this section of the Plan or as otherwise required or permitted by the Privacy Rules. PHI means information that is created or received by the Plan and relates to:

- past, present, and future physical or mental health or condition of an individual;
- provision of health care to an individual; or
- past, present, or future payment for the provision of health care to an individual;

and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual.

PERMITTED USES AND DISCLOSURES

The Plan may disclose PHI to the University only if the Privacy Rules specifically permit the use or disclosure, or if the individual in writing authorizes the Plan to use or

disclose PHI to the University. In no event will the Plan disclose PHI to the University before it receives certification from the University that the Plan incorporates the “University’s Privacy Obligations” listed below.

Once the University receives PHI from the Plan, it may use or disclose PHI only for Plan administration functions. “Plan administration functions” are administrative tasks performed by the University on behalf of the Plan and not employment-related functions or functions performed by the University in connection with any other benefit or benefit plan of the University. Plan administration functions include, but are not limited to:

- Enrollment and disenrollment activities;
- Verification of participation in the Plan;
- Obtaining premium contributions;
- Determining eligibility for benefits;
- Activities to coordinate benefits with other plans and coverages;
- Final adjudication of appeals of claim denials;
- Exercise of the Plan’s rights of reimbursement and subrogation;
- Assisting participants in eligibility, benefit claims matters, inquiries, and appeals;
- Obtaining premium bids;
- Evaluation of health plan design;
- Activities relating to placement, renewal, or replacement of a contract of health insurance or health benefits (including stop-loss and excess loss insurance);
- Legal services and auditing functions (including fraud and abuse detection);
- Business planning, management and general administration;
- Making claims under stop-loss or excess loss insurance;
- Activities in connection with the transfer, merger or consolidation of the Plan, including due diligence.

UNIVERSITY’S PRIVACY OBLIGATIONS

With respect to any PHI created by or received from the Plan, the University will:

- not use or further disclose the PHI other than as permitted or required by this Plan or as required by law;
- ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the University with respect to such PHI;

- not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the University unless authorized by an individual;
- report to the Plan any PHI use or disclosure of which it becomes aware that is inconsistent with the Privacy Rules;
- make PHI available to an individual in accordance with the access requirements of the Privacy Rules;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Rules;
- make available the information required to provide an accounting of disclosures;
- make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for purposes of determining the Plan's compliance with the Privacy Rules;
- if feasible, return or destroy all PHI received from the Plan that the University still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- ensure that adequate separation between the Plan and the University as required by the Privacy Rules is satisfied and that the requirements listed in the next section ("Adequate Separation Between Plan and University") are followed.

ADEQUATE SEPARATION BETWEEN PLAN AND UNIVERSITY

Adequate separation between the Plan and the University will be maintained. Only the employees or classes of employees identified in University's privacy policies and procedures ("authorized employees") will be given access to PHI. The section of the University's privacy policies and procedures that lists these employees is incorporated by reference herein. The access to and use of PHI by these authorized employees is restricted to the Plan administration functions that the University performs for the Plan.

If an authorized employee uses or discloses PHI in ways other than those permitted by the Plan or the Privacy Rules, he or she will be subject to the disciplinary procedures in the University's employee handbook or policy manual or, if applicable, collective bargaining agreement. The University may impose, at its discretion,

reasonable sanctions necessary to ensure that no further non-compliance with the Plan or the Privacy Rules occurs.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A Qualified Medical Child Support Order (QMCSO) is a court order under state domestic relations law generally issued as part of a settlement agreement or judgment of divorce, that provides group health (medical, dental or vision) coverage for the child of a Participant. The Plan will honor a QMCSO if it meets the following requirements. The order must:

- Create or recognize the existence of the child's right to receive group health benefits for which the Participant is eligible under the Plan;
- Clearly specify the name and last known mailing address of the participant and the name and mailing address of each child covered by the court order;
- Specify a reasonable description of the type of coverage to be provided by the Plan to each child or the manner in which the type of coverage is to be determined; and
- Specify each group health plan to which the order applies and the period to which it applies.

The order may not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan.

The term "Alternate Recipient" means any child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan.

When a Plan Administrator receives a medical child support order, it will:

- notify in writing the participant and each Alternate Recipient of the receipt of the order together with an explanation of the criteria for determining whether the court order qualifies as a QMCSO;
- determine if the order is qualified; and
- notify the Participant and each Alternate Recipient in writing of the determination.

The Plan Administrator or its designee is responsible for deciding if the court order satisfies the conditions of a QMCSO.