



2010 Employee Benefits Plan Compliance and Annual Disclosure Notices

Prepared for:

Long Beach Community College District

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SUMMARY OF COMPLIANCE AND ANNUAL DISCLOSURE NOTICES

ERISA and various other state and federal laws requires that employers provide disclosure and annual notices to their plan participants. The attached materials are provided to assist in the employer's reporting and disclosure requirements.

Following is a brief descriptions of the attached Compliance and Annual Disclosure Notices:

COBRA Compliance Group Health Continuation Coverage

Federal law requires that most employers sponsoring group health plans offer employees and their families the opportunity of extension of health coverage (called "COBRA continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This general notice is intended to inform employees of their rights and obligations under the law.

ERISA Compliance Statement of Rights

ERISA provides that a Plan participant shall be entitled to receive information about his/her plan and benefits, continue group health plan coverage, prudent actions by plan fiduciaries, and enforce his/her rights.

HIPAA Compliance Privacy Notice

This notice is intended to inform employees of the privacy practices followed by your company's group health plan. It also explains the federal privacy rights afforded to you and the members of your family as plan participants covered under a group plan.

HIPAA Special Enrollment Rights

Plan participants are entitled to certain special enrollment rights outside of the company open enrollment period. This notice provides information on special enrollment periods for loss of prior coverage or addition of a new dependent.

Children's Health Insurance Program Compliance

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. This notice provides information on how to contact your State Medicaid office to receive information on assistance.

Medicare Part D Creditable Coverage Letter

Plans are required to provide each covered participant and dependent a Certificate of Credible coverage to qualify for enrollment in Medicare Part D prescription drug coverage when qualified without a penalty.

Medicare Part D Creditable Coverage Letter - Written Procedures

This notice provides a written procedure for individuals to request and receive Certificates of Creditable Coverage.

The Newborn and Mother's Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) affects the amount of time a mother and her newborn child are covered for a hospital stay following childbirth.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) contains important protections for breast cancer patients who choose breast reconstruction with a mastectomy. The US Departments of Labor and Health and Human Services are in charge of this act of law which applies to group health plans if the plans or coverage provide medical and surgical benefits for a mastectomy.

Family Medical Leave Act

The Family & Medical Leave Act (FMLA) allows "eligible" employees to take off up to 12 work weeks in any 12 month period for the birth or adoption of a child, to care for a family member, or if the employee themselves has serious health condition.

On April 7, 1986, a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. Individuals entitled to COBRA continuation coverage are referred to as "qualified beneficiaries." COBRA continuation coverage applies to employer-sponsored group or individual medical, dental, vision, prescription drug plans, certain health flexible spending accounts, and other arrangements that provide similar benefits.

This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provision of the law. (Both you and your spouse should take time to read this notice carefully.)

If you are an employee covered under the group health plan, you have an independent right to choose COBRA continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are covered under the group health plan as the spouse of an employee, you have an independent right to choose COBRA continuation coverage if you lose group health coverage due to any of the following four qualifying events:

- (1) The death of your spouse;
- (2) A termination of your spouse's employment or reduction in your spouse's hours of employment;
- (3) Divorce or legal separation from your spouse; or
- (4) Your spouse becomes entitled* to Medicare.

In the case of a dependent child of an employee, covered under the group health plan, he or she has an independent right to choose COBRA continuation coverage if group health coverage is lost due to any of the following five qualifying events:

- (1) The death of the parent;
- (2) The termination of the parent's employment or reduction in the parent's hours of employment;
- (3) Parent's divorce or legal separation;
- (4) The parent becomes entitled* to Medicare; or
- (5) The dependent ceases to be a dependent child, as defined in the group health plan.

A child who is born to or placed for adoption with a covered employee during a period of continuation coverage is deemed a qualified beneficiary for COBRA purposes. The newborn or adopted child must be added to COBRA coverage within the time frame allowed by the plan. The newborn or adopted child's continuation coverage period is measured from the original date that COBRA coverage began.

You cannot lose your COBRA rights if you have other health care coverage (including Medicare entitlement) *prior to* electing COBRA continuation coverage. Similar rights may apply to certain retirees, spouses, and dependent children of a retiree if the employer commences a bankruptcy proceeding and these individuals lose coverage within 12 months before or after the date on which the bankruptcy proceeding begins.

Under the law, the covered employee or a family member has the responsibility to inform the employer of a divorce, legal separa-

tion, or a child losing dependent status under the terms of the group health plan within 60 days after the date of the qualifying event or the date on which the qualified beneficiary would lose coverage because of the qualifying event, whichever is later. This notice must be made in writing and sent to your employer at the address shown on the enclosed "Notification of COBRA Dependent Qualifying Event" form. If there is a loss of coverage in anticipation of a qualifying event, you may still be entitled to continuation coverage. If this applies to you, please notify your employee benefits representative immediately to determine your COBRA rights.

When a qualifying event has occurred, you will be notified in writing at your last known address that you have the right to continue your coverage. Under the law, you have a 60-day election period during which you must inform Long Beach Community College District in writing that you want continuation coverage. This election period begins on the later of: (1) the date you lose coverage due to one of the events described above, or (2) the date you are provided your COBRA election notification. Each qualified beneficiary has independent election rights. However, a covered employee or the spouse of the covered employee may elect continuation coverage for all qualifying family members. If you are or become mentally or physically incapacitated during this election period, an appointed guardian or responsible party may elect and/or pay for COBRA continuation coverage on your behalf.

Under COBRA, you must be offered the opportunity to elect the group health plan coverage that is provided to active employees. Ordinarily, this will be the same coverage you had on the day before the qualifying event. You must also be offered the same HIPAA rights as active employees at open enrollment and special enrollment periods. Your continuation coverage is subject to change if coverage under the plan is modified for active employees.

If you choose continuation coverage, your election (or payment) is considered made on the date you send your election form (or payment) to Long Beach Community College District. If you do not choose and pay for continuation coverage, your group health coverage will end in accordance with the terms of the plan and you will cease to be a qualified beneficiary at the end of the election period.

Under the law, you must pay the premium for COBRA continuation coverage. The plan has the right to charge up to 102 percent of the applicable premium for this coverage on a monthly basis. Premiums are due on the first of the month for the month of coverage. You have 45 days from the date you elect continuation coverage to pay the initial premium. A 30-day grace period applies to all subsequent premium payments.

The law requires that you be given the opportunity to maintain continuation coverage for three years, unless you lost group health coverage due to employment termination or a reduction in hours of employment. In that case, the required continuation coverage period is 18 months.

COMPLIANCE NOTICE

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

A continuation coverage period of 18 months may be extended to 29 months if any qualified beneficiary is determined to have been disabled (under Title II or XVI of the Social Security Act) at any time during the first 60 days of COBRA continuation coverage.

In the case of a newborn or adopted child, the 60-day period is measured from the date of the child's birth or placement for adoption. To qualify for this extension, Long Beach Community College District must be provided with a copy of the Social Security Administration disability determination letter (commonly referred to as a "Notice of Award") within 60 days after the date the determination is issued and before the end of the original 18-month continuation coverage period.

If the qualifying event occurs within 18 months after the employee became entitled to Medicare, the covered spouse or dependent children are entitled to a COBRA coverage period that ends 36 months after the employee became entitled to Medicare.

The disabled individual may be any qualified beneficiary (former employee, spouse or dependent). Additionally, the disability extension applies independently to non-disabled family members who are qualified beneficiaries due to the termination or reduction in hours of employment. Long Beach Community College District must be notified within 30 days of any final determination that the individual is no longer disabled.

As mentioned above, the plan can require 102 percent of the applicable premium for continuation coverage. However, if coverage is extended due to a disability and the disabled individual is part of the coverage group, the plan may charge up to 150 percent of the applicable premium during the disability extension period. If only non-disabled qualified beneficiaries are in the coverage group, 102 percent of the applicable premium would apply.

A continuation coverage period of 18 or 29 months may be extended to 36 months for eligible dependent qualified beneficiaries if a second qualifying event occurs (such as employee death, divorce, legal separation, employee Medicare entitlement* or a child losing dependent status) during the 18- or 29- month period and which would result in the loss of coverage for the dependents of a similarly-situated active employees. The extension applies only if Long Beach Community College District is notified in writing within 60 days of the second qualifying event and within the original 18- or 29- month coverage period. In no event will continuation coverage last beyond three years from the date of the event that originally made a qualified beneficiary eligible to elect coverage. A reduction in hours followed by a termination of employment is not considered a second qualifying event for COBRA purposes.

Near the end of an 18-, 29- or 36-month continuation coverage period, you will be notified of your right to convert from group coverage to an individual policy (if such conversion option is available under the provisions of the group health plan).

The law provides that your continuation coverage may be cut short for any of the following reasons:

- (1) The employer no longer provides group health coverage to any of its employees;
- (2) The premium for your continuation coverage is not paid on time;

***Note:** An employee is considered entitled to Medicare Part A if he or she is age 65 or over and receives (or has applied for) Social Security or is entitled to Medicare/Social Security at an earlier age due to a disabling condition.

- (3) You become covered under another group health plan, after the date of COBRA election, that does not contain any applicable exclusion or limitation period with respect to any pre-existing condition you may have. (This rule applies only to the qualified beneficiary who becomes covered by another group health plan);
- (4) You become entitled* to Medicare, after the date of COBRA election;
- (5) You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled. In such cases, coverage for all qualified beneficiaries will end with the first month beginning more than 30 days after the SSA determination or, if later, at the end of 18 months of continuation coverage;
- (6) You request cancellation of COBRA continuation coverage in writing;
- (7) The group health plan terminates coverage for cause on the same basis as for an active employee.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits as follows.

If you become covered under another group health plan, and that group health plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the group health plan may terminate your coverage.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the plan reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

This notice does not fully describe continuation or other rights under the plan. Rather, this notice provides you with a broad overview of a complex federal employer law. Please refer to your copy of the Insurance Benefits Certificate, Summary Plan Description or Plan Document for specific details about your plan benefits. More information is available to you online at the U.S. Department of Labor, Employee Benefit Security Administration website (www.dol.gov/ebsa).

If you have a change of marital status, or you, your spouse or dependent child have a change of address, you must notify your employer.

Special COBRA rights apply to employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days (or less) and only during the first six months immediately after their group health plan coverage ended. If you qualify or may qualify for assistance under the Trade Act of 1974, contact the plan administrator for additional information. You must contact the plan administrator promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights.

Plan participants are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that a Plan participant shall be entitled to:

Receive Information About Your Plan and Benefits. This includes the right to:

- examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- obtain, upon written request to the Plan Administrator, copies of documents governing the operation of a Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Where permitted by law, these documents may be provided electronically; and
- receive a summary of a Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage. This includes:

- the right to continue health care coverage for himself/herself, spouse or dependents if there is a loss of coverage under a Plan as a result of a Qualifying Event. The employee or his/her dependents may have to pay for such coverage. See the **COBRA Continuation Coverage** section for additional details about these rights; and
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under a Plan, if he/she has creditable coverage from another plan. An individual should be provided a certificate of creditable coverage, free of charge, from his/her group health plan or health insurance issuer when he/she loses coverage under a plan, when he/she becomes entitled to elect COBRA continuation coverage, when his/her COBRA continuation coverage ceases, if he/she requests it before losing coverage or if he/she requests it up to 24 months after losing coverage. Without evidence of creditable coverage, he/she may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after his/her enrollment date in the Plan.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of a Plan (the fiduciaries). Fiduciaries have a duty to operate a Plan prudently and in the interest of Plan participants and beneficiaries. No one, including the employer, may fire a Plan participant or discriminate against him/her to prevent him/her from obtaining a welfare benefit or exercising rights under ERISA.

If an individual's claim for a welfare benefit is denied in whole or in part, he/she must receive a written explanation of the reason for the denial. He/she has the right to have the Plan Administrator review and reconsider his/her claim.

Enforce Your Rights

Under ERISA there are steps a Plan participant can take to enforce the above rights. For instance, if he/she requests materials from a Plan and does not receive them within 30 days, he/she may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay him/her up to \$110 a day until he/she receives the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If he/she has a claim for benefits which is denied or ignored, in whole or in part, he/she may file suit in a Federal court. In addition, if he/she disagrees with the Plan decision or lack thereof, concerning the qualified status of a medical child support order (QMCSO), he/she may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if he/she is discriminated against for asserting his/her rights, he/she may seek assistance from the U.S. Department of Labor, or he/she may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If he/she is successful, the court may order the person he/she has sued to pay these costs and fees. If he/she loses, the court may order him/her to pay these costs and fees, for example, if it finds his/her claim are frivolous.

Assistance With Questions

If a Plan participant has any questions about a Plan, he/she should contact the Plan Administrator. If he/she has any questions about this statement or about his/her rights under ERISA, he/she should contact:

- (1) the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor as listed in his/her telephone directory, or
 - (2) the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.
- A Plan participant may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 463-3278.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

OUR COMPANY'S PLEDGE TO YOU

This notice is intended to inform you of the privacy practices followed by the Long Beach Community College District Group Health Plan. It also explains the federal privacy rights afforded to you and the members of your family as plan participants covered under a group health plan.

As a plan sponsor, Long Beach Community College District often needs access to health information in order to perform plan administrator functions. We want to assure the plan participants covered under our group health plan that we comply with federal privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to health information comply with the privacy practices outlined below.

USES AND DISCLOSURES OF HEALTH INFORMATION

Health Care Operations - We use and disclose health information about you in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

Payment - We may also use or disclose identifiable health information about you without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Treatment - Although the law allows use and disclosure of your health information for purposes of treatment, as a plan sponsor we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As Permitted or Required by law - We may also use or disclose your health information without your written authorization for other reasons as *permitted* by law. We are *permitted* by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g. preventing the spread of disease) without your written authorization. We are also permitted to share health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when *required* by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization - When required by law, we will ask for your written authorization before using or disclosing your identifiable health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to cease any future uses or disclosures.

INDIVIDUAL RIGHTS

Right to Inspect and Copy - In most cases, you have a right to inspect and copy the health information we maintain about you. If you request copies, we will charge you \$0.05 (5 cents) for each page. Your request to inspect or review your health information must be submitted in writing to the person listed below.

Right to an Accounting of Disclosures - You have a right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes.

Right to Amend - If you believe that information within your records is incorrect or if important information is missing, you have a right to request that we correct the existing information or add the missing information.

Right to Request Restrictions - You may request in writing that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications - You have a right to receive confidential communications containing your health information. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to Receive a Paper Copy of this Notice - If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

OUR LEGAL DUTIES

We are required by law to protect the privacy of your information, provide this notice about information practices, and follow the information practices that are described in this notice. We may change our policies at any time. Before we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time.

For more information about our privacy practices, or if you have any questions or complaints, please contact:

Contact--Position/Office:	Evelyn Reed
Name of Entity/Sender:	Long Beach Community College District
Address:	4901 East Carson, Long Beach, CA 90808
Phone Number:	(562) 938-4531
Date:	April 1, 2010

COMPLAINTS

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information.

If you are declining enrollment for yourself or your dependent (s) (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents if you or your dependent (s) lose eligibility for other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Long Beach Community College District group health plan will allow an employee or dependent who is eligible, but not enrolled for coverage, to enroll for coverage if either of the following events occur:

1. Special Enrollment Due to Loss of Other Coverage

A special enrollment opportunity occurs when either you or your dependent (s) had other health coverage but are no longer eligible for that coverage. You must notify your employer's plan within **30 days** of the date of the event. The loss of eligibility may have occurred for a number of reasons, including the following:

- Termination of employment
- Reduction in hours of employment
- Divorce or legal separation
- Exhaustion of COBRA coverage (loss of eligibility due to failure to pay premiums or termination for cause does not create a special enrollment opportunity)
- Loss of eligibility for Medicaid or CHIP

2. Special Enrollment Due to Marriage, Birth or Adoption

Marriage, birth, and adoption create special enrollment opportunities for the current employee and he or her spouse and new dependent (s). You must notify your employer's plan within **30 days** of the date of the event.

3. Enrollment Rights - Children's Health Insurance Program

- Loss of Eligibility for State Children's Health Insurance Program (SCHIP) or Medicaid - Eligible participants (which may include dependents of participants) who are not enrolled in the Plan have the right to enroll in the Plan for coverage in the event the eligible participant's enrollment in a SCHIP or as an enrollee in Medicaid is terminated due to a loss of eligibility. Eligible individuals must be given **60 days** after the loss of coverage or determination of eligibility for assistance to request coverage under the group health plan.
- Eligibility for Premium Subsidy Under Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) - In the event that a participant or an eligible participant becomes eligible for premium assistance subsidy through SCHIP or Medicaid, that eligible participant shall have **60 days** to notify the plan administrator in writing of their interest in enrollment, provide proof of eligibility and provide the necessary information to complete the enrollment.
- Disenrollment Rights Due to Eligibility for SCHIP - In the event that a participant in the Plan becomes eligible for enrollment in Medicaid or a SCHIP program, that participant is permitted to terminate their group coverage by providing notice of eligibility for the publically -funded health program and completing the necessary paperwork to terminated the existing coverage through the group health plan.

To request special enrollment or obtain more information, please contact:

Contact--Position/Office: Evelyn Reed
Name of Entity/Sender: **Long Beach Community College District**
Address: 4901 East Carson, Long Beach, CA 90808
Phone Number: (562) 938-4531
Date: April 1, 2010

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in California, you can contact your Medicaid office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs you can contact the California Medicaid office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State of California if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependent are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan - as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within **60 days** of being determined eligible for premium assistance.

If you live in California, you may be eligible for assistance paying your employer health plan premiums. You should use the contact information below for further information on eligibility:

CALIFORNIA - Medicaid

Website: <http://www.dhcs.ca.gov/Pages/default.aspx>

Phone: (800) 635-2570

To see if any more States have added a premium assistance program, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/ebsa

(866) 444-3272

U.S. Department of Health and Human Services Center for Medicare & Medicaid Services

www.cms.hhs.gov

(877) 267-2323, ext. 61565

Important Notice from Long Beach Community College District About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Long Beach Community College District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Long Beach Community College District has determined that the prescription drug coverage offered by the Anthem Blue Cross plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Long Beach Community College District coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you decide to join a Medicare drug plan and drop your current Anthem Blue Cross plan coverage, be aware that you and your dependents will be able to get this coverage back. You (and your dependents— if applicable) can re-enroll during an open enrollment period or upon a special enrollment period as provided by HIPAA or applicable state law. Normal plan eligibility rules apply.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Long Beach Community College District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Long Beach Community College District changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Contact--Position/Office:	Evelyn Reed
Name of Entity/Sender:	Long Beach Community College District
Address:	4901 East Carson, Long Beach, CA 90808
Phone Number:	(562) 938-4531
Date:	April 1, 2010

CMS Form 10182-CC

Updated January 1, 2009

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimates) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Important Notice from Long Beach Community College District About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Long Beach Community College District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Long Beach Community College District has determined that the prescription drug coverage offered by the Kaiser plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Long Beach Community College District coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you decide to join a Medicare drug plan and drop your current Kaiser plan coverage, be aware that you and your dependents will be able to get this coverage back. You (and your dependents— if applicable) can re-enroll during an open enrollment period or upon a special enrollment period as provided by HIPAA or applicable state law. Normal plan eligibility rules apply.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Long Beach Community College District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Long Beach Community College District changes. You also may request a copy of this notice at any time.

ANNUAL NOTICE

KAISER— INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Contact--Position/Office:	Evelyn Reed
Name of Entity/Sender:	Long Beach Community College District
Address:	4901 East Carson, Long Beach, CA 90808
Phone Number:	(562) 938-4531
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**To Request Creditable Coverage
For Prescription Drug Coverage and Medicare
On Long Beach Community College District Medicare Prescription Drug Plans**

The Medicare Modernization Act (MMA) imposes a late enrollment penalty on individuals who do not maintain Creditable Coverage for a period of 63 days or longer following their initial enrollment period for the Medicare prescription drug benefit. MMA mandates that certain entities offering prescription drug coverage, including employer and union group health plan sponsors, disclose to all Medicare eligible individuals with prescription drug coverage under the plan whether such coverage is "creditable." This information is essential to an individual's decision whether to enroll in a Medicare Part D prescription drug plan.

Please refer to your Medicare Creditable Coverage Notice that has information about your current prescription drug coverage with Long Beach Community College District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan.

In the future you may decide to join one of the Medicare drug plans and you may be required to provide a copy of the Prescription Creditable Coverage Notice when you join to show whether or not you have maintained creditable coverage. This is important as if you have not had Creditable Coverage you may be required to pay a higher premium (a penalty).

If you need to request a personal Creditable Coverage Certificate for Long Beach Community College District medical plans, please contact:

- ANTHEM
Carrier Customer Service
HMO: (800) 227-3613
PPO: (800) 888-8288

Plan Effective Date: 7/1/2010—6/30/2011

- KAISER
Carrier Customer Service
HMO: (800)-966-5955

Plan Effective Date: 7/1/2010—6/30/2011

Contact--Position/Office:	Evelyn Reed
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The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) affects the amount of time you and your newborn child are covered for a hospital stay following childbirth. The law applies both to persons enrolled in group health plans and to persons who have individual health care coverage. In general, plans and health insurance issuers that are subject to NMHPA may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

If you deliver in the hospital, the 48-hour (or 96-hour) period starts at the time of delivery. If you deliver outside the hospital and you are later admitted to the hospital in connection with childbirth, the period begins at the time of the admission.

Although the NMHPA prohibits group health plans and health insurance issuers from restricting the length of a hospital stay in connection with childbirth, the plan or health insurance issuer does not have to cover the full 48 or 96 hours in all cases. If an attending provider, after speaking with you, determines that either you or your child can be discharged before the 48-hour (or 96-hour) period, the group health plan and health insurance issuers do not have to continue covering the stay for whichever one of you is ready for discharge. An attending provider is an individual, licensed under State law, who is directly responsible for providing maternity or pediatric care to you or your newborn child. In addition to physicians, an individual such as a nurse midwife, physician assistant, or nurse practitioner may be an attending provider. A plan, hospital, insurance company, or HMO would NOT be an attending provider.

Two key factors determine whether NMHPA protections apply to your health insurance coverage.

First, protection depends on whether the benefits under your group health plan or insurance policy include coverage for hospital stays following childbirth. NMHPA does NOT require group health plans and health insurance issuers to provide that kind of coverage.

Second, even if your group health plan or health insurance issuer chooses to cover hospital stays in connection with childbirth, you need to find out how your group health plan provides benefits. Group health plans that provide benefits through insurance are known as insured plans. Group health plans that pay for coverage directly, without purchasing health insurance from an issuer, are called self-insured plans.

Contact your health plan administrator if you need additional information.

If you have had a mastectomy or expect to have one, you may be entitled to special rights under the Women's Health and Cancer Rights Act of 1998 (WHCRA). The following questions and answers clarify your basic WHCRA rights. Under WHCRA, if your group health plan covers mastectomies, the plan must provide certain reconstructive surgery and other post-mastectomy benefits.

FREQUENTLY ASKED QUESTIONS ABOUT WHCRA

I've been diagnosed with breast cancer and plan to have a mastectomy. How will WHCRA affect my benefits?

Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage also must provide coverage for certain services relating to the mastectomy in a manner determined in consultation with your attending physician and you. This required coverage includes all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications of the mastectomy, including lymphedema .

I have not been diagnosed with cancer. However, due to other medical reasons I must undergo a mastectomy. Does WHCRA apply to me?

Yes, if your group health plan covers mastectomies and you are receiving benefits in connection with a mastectomy. Despite its name, nothing in the law limits WHCRA rights to cancer patients.

Does WHCRA require all group health plans, insurance companies and HMOs to provide reconstructive surgery benefits?

Generally, group health plans, as well as their insurance companies and HMOs, that provide coverage for medical and surgical benefits with respect to a mastectomy must comply with WHCRA.

However, if your coverage is provided by a "church plan" or "governmental plan", check with your plan administrator. Certain plans that are church plans or governmental plans may not be subject to this law.

May group health plans, insurance companies or HMOs impose deductibles or coinsurance requirements on the coverage specified in WHCRA?

Yes, but only if the deductibles and coinsurance are consistent with those established for other benefits under the plan or coverage.

I just changed jobs and am enrolled under my new employer's plan. I underwent a mastectomy and chemotherapy treatment under my previous employer's plan. Now I want reconstructive surgery. Under WHCRA, is my new employer's plan required to cover my reconstructive surgery?

If your new employer's plan provides coverage for mastectomies and if you are receiving benefits under the plan that are related to your mastectomy, then your new employer's plan generally will be required to cover reconstructive surgery if you request it. In addition, your new employer's plan generally is required to cover other benefits specified under WHCRA. It does not matter that your mastectomy was not covered by your new employer's plan.

However, a group health plan may limit benefits relating to a health condition that was present before your enrollment date in your current employer's plan through a preexisting condition exclusion. A Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which a preexisting condition exclusion may be applied.

Specifically, HIPAA provides that a plan may impose a preexisting condition exclusion only if:

- The exclusion relates to a condition (whether physical or mental) for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on your enrollment date.
- The exclusion extends no more than 12 months (or 18 months in the case of a late enrollee in the new plan) after the enrollment date.
- The preexisting condition exclusion period is reduced by the days of prior creditable coverage (if any, which is defined in HIPAA as most health coverage).

The plan also must provide you with written notification of the existence and terms of any preexisting condition exclusion under the plan and of your rights to demonstrate prior creditable coverage.

ANNUAL NOTICE

My employer's group health plan provides coverage through an insurance company. Following my mastectomy, my employer changed insurance companies. The new insurance company is refusing to cover my reconstructive surgery. Does WHCRA provide me with any protections?

Yes, as long as the new insurance company provides coverage for mastectomies, you are receiving benefits under the plan related to your mastectomy, and you elect to have reconstructive surgery. If these conditions apply, the new insurance company is required to provide coverage for breast reconstruction as well as the other benefits required under WHCRA. It does not matter that your mastectomy was not covered by the new insurance company.

I understand that my group health plan is required to provide me with a notice of my rights under WHCRA when I enroll in the plan. What information can I expect to find in this notice?

Plans must provide a notice to all employees when they enroll in the health plan describing the benefits that WHCRA requires the plan and its insurance companies or HMOs to cover.

These benefits include coverage of all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedema.

The enrollment notice also must state that for the covered employee or their family member who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient.

Finally, the enrollment notice must describe any deductibles and coinsurance limitations that apply to the coverage specified under WHCRA. Deductibles and coinsurance limitations may be imposed only if they are consistent with those established for other benefits under the plan or coverage.

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

Source: WHD Publication 1420 Revised January 2009



BURNHAM BENEFITS
INSURANCE SERVICES

Burnham Benefits Insurance Services

2 Park Plaza, Suite 550, Irvine, CA 92614

Phone: 949.833.2983 Fax: 949.833.9549

www.burnhambenefits.com
