



Important Information About Your Rights

Benefit programs are highly regulated by federal and state legislation. These regulations are designed to give us specific operational guidelines and to protect participants' rights and access to information. We are legally required to give you some of the following information. We have included other important information as part of LACCD's commitment to provide our plan participants with everything they need to take full advantage of our benefit programs.

General Eligibility Rules

Active Employee Eligibility

You are eligible to enroll in the LACCD Group Health Benefits Plan if you are a regular, active District employee with a work load of at least a .5 FTE. You may continue your participation in the LACCD Group Health Benefits Plan under COBRA when you separate from District service or lose eligibility.

Adjunct Employee Eligibility

Your eligibility for benefits depends on how many hours you're scheduled to teach. Your teaching load also determines the cost of your benefits and how you pay for your coverage.

As a part-time temporary faculty or temporary adjunct faculty member, you are eligible to enroll in the LACCD Health Benefits **Premium Only Plan** (POP) and receive the District's contribution toward the medical premium IF:

- You have been assigned and are currently working a .33 (or higher) FTE temporary (limited or long-term substitute) or adjunct faculty load in the District, and you have completed at least a .2 FTE part-time temporary faculty or temporary adjunct faculty position in the District during three or more semesters out of the previous eight consecutive semesters;
- You are requesting coverage during the specific enrollment period in the semester (Fall or Spring only) in which you are eligible;
- You sign an Affidavit at the start of each academic year that neither you nor your dependents are eligible for employer-sponsored hospital/medical coverage through another employer or your spouse's employer; and
- You complete and return the enrollment materials selecting your benefit choices by the enrollment deadline.

To enroll in a CalPERS medical plan, you must also be in one of the following retirement systems: CalSTRS (DB or CB plan), PARS, or PERS.

You may continue your participation in the LACCD Group Health Benefits Plan under COBRA when you separate from District service or lose eligibility.

Retiree Eligibility

The District's health benefit plans for retirees are available to active employees who retire under the rules of the California Public Employee Retirement System (CalPERS) or California State Teachers Retirement System (CalSTRS), receive a retirement allowance from that system, and have provided uninterrupted District service in a qualifying position. See HR Guide P-371 for details.

A retiree in CalSTRS who is NOT eligible to continue his or her coverage in the LACCD Group Health Plan is entitled to continue coverage under the provisions of AB 528.

Dependent Eligibility

You may enroll your dependents for coverage if they are:

- » Your legally married spouse.
- » Your domestic partner, as specified in your collective bargaining agreement.
- » Your unmarried dependent children under age 19. Children are your (or your qualified domestic partner's) natural, adopted, step- and foster children.
- » Your unmarried dependent children age 19 through 25 who are full-time students at a college or university.
- » Your unmarried dependent children without regard to age who are physically or mentally incapacitated, and who are being claimed as dependents on the employee's federal income tax returns. However, if you were hired after October 1, 2002, your disabled child's coverage under this subsection must be a continuation of his or her coverage under the Health Benefits Program. In other words, your child must be disabled *before* reaching age 19, unless you are a new employee enrolling for the first time. If there is ever a break in your disabled child's coverage, he or she will not be eligible to re-enroll.

Domestic Partner Eligibility

Your domestic partner is someone of the same sex (or the opposite sex, if one of you is at least age 62) with whom you live in a committed relationship. Your relationship must meet all of the following criteria:

- » You share the same regular and permanent residence, and have been living as a couple in the same household for at least 12 months;
- » You have a close personal relationship in lieu of a lawful marriage;
- » You have agreed to be jointly responsible for basic living expenses incurred during the partnership;
- » You are not married to anyone;
- » You are each eighteen (18) years of age or older;
- » You are not related by blood as close as would bar marriage;
- » You are mentally competent to consent to a contract;

- » You are each other's sole domestic partner and are responsible for each other's common welfare; and
- » You acknowledge joint ownership of acquisitions since the start of the partnership, to an extent equal to that pertaining to community property in the case of marriage.

You must also be registered as domestic partners with the State of California. To learn more about registering a domestic partner, visit the California Domestic Partner Registry online at www.ss.ca.gov/dpregistry.

To add a domestic partner as a dependent on your health plan, please refer to your collective bargaining agreement.

Taxation of Benefits for Domestic Partners

LACCD will make the same contribution toward your domestic partner's coverage as we do for a legal spouse's coverage; we will pay the same share of your domestic partner's dependent child's coverage as we pay for your own dependent child's coverage. Because federal tax law does not recognize domestic partnership, these employer-provided contributions will be treated as taxable income to you; you will see them reported on your annual Form W-2 as "imputed income." You will have to pay federal, FICA (Social Security and Medicare), state, and (where applicable) city income taxes on the amount contributed by LACCD toward health care coverage for your domestic partner and his or her children.

Certain exceptions apply. If your domestic partner (or your domestic partner's child) qualifies as a Section 152 tax dependent, the value of the benefits that LACCD provides is not subject to federal income tax. Also, in some states (including California), the value of health benefits provided to registered domestic partners is excluded from state income tax.

Section 152 Tax Dependents

Under Internal Revenue Code Section 152, an individual is defined as a “dependent” if he or she is either (1) a qualifying child or (2) a qualifying relative.

A qualifying child is an individual who:

- » Bears a specific familial-type relationship with the taxpayer: (i) a child (natural, adopted, foster, and/or stepchild), and a descendant of such child; and (ii) a brother or sister (including step) and a descendant of such brother or sister;
- » Does not provide over half of his/her own support;
- » Has the same principal place of abode as the taxpayer for more than half the year; and
- » Does not turn age 19 (age 24 if a full-time student) by the end of the taxable year. (Children who are permanently and totally disabled are excluded from the age limit.)

A qualifying relative is an individual who:

- » Bears a specific familial-type relationship to the taxpayer:
 - a child (natural, adopted, foster, and/or stepchild) and descendent of such child
 - a brother or sister (including step siblings)
 - parent or ancestor
 - stepparent (not including ancestors)
 - aunt/uncle
 - niece/nephew
 - in-laws; or
 - any other individual not listed above (i.e., a non-relative) who has the same principal place of abode as the taxpayer and lives with the taxpayer. Even though not related, the fact that they may receive over half their support from the taxpayer and live with the taxpayer causes them to be treated the same as other family members.
- » Has gross income less than the §151(d) exemption amount;
- » Is not a “qualifying child” of any taxpayer; and
- » Receives over half of his or her support from the taxpayer.

Contact your tax adviser for more information.

When Coverage Begins

Active and Retired Employees

Coverage for you and your eligible dependents will become effective the first day of the month following receipt of your enrollment forms, if you become eligible and your enrollment forms are received prior to the 15th of the month. If you become eligible and your forms are received after the 15th, your coverage will become effective the first day of the second following month. Under your collective bargaining agreement, you may enroll at any time as long as you meet the eligibility requirements.

Newborn infants will be eligible immediately after birth for the first 31 days. Children placed for adoption will be eligible immediately upon the date you, your spouse, or your domestic partner has the right to control the child's health care. Evidence of such control includes a health facility minor release report, a medical authorization form or a relinquishment form.

You must provide a copy of your newborn's birth record from the hospital, or adoption paperwork, within the first 31 days to add him or her to your LACCD health plan coverage.

Part-Time Faculty

Coverage for you and your eligible dependents will become effective the first day of the month in which the spring or fall semester begins. Under your collective bargaining agreement, you may enroll as long as you meet the eligibility requirements each semester.

Special Enrollment Periods for Health Care Coverage

Active and Retired Employees

If you do not enroll yourself or your eligible dependents for medical coverage when you are first eligible but you later wish to enroll, under your collective bargaining agreement you are permitted to enroll once you submit all required paperwork and documentation.

Part-Time Faculty

If you do not enroll yourself or your eligible dependents for medical coverage during the semester in which you are eligible but you wish to enroll later in the semester, you will have to wait until the next open enrollment period unless you qualify for a "special enrollment period." A special enrollment period is available to a person who meets one of the following criteria:

- » If you declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage or qualifying state coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. This special rule applies if you or your dependents lose the other

coverage due to termination of employment, change in employment status, termination of the other plan's coverage, cessation of the employer's contribution toward coverage, exhaustion of COBRA coverage, death of a spouse, divorce, legal separation, or loss of qualifying state coverage.

Even if you do not meet the 31-day requirement, the plan must allow you to enroll if you did not initially sign a written waiver of coverage stating that the reason you were waiving coverage was because you had other coverage and acknowledging that such waiver may cause you (and your dependents) to be treated as a late enrollee if you subsequently request enrollment.

- » If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. If you are eligible for coverage but do not enroll, your dependents cannot enroll.
- » If a court of competent jurisdiction has ordered you to provide coverage for your spouse or minor child, you may enroll that individual mid-year if you make your request for enrollment to LACCD within 31 days of the date the court order was issued.

When Coverage Ends

Health care coverage for you and/or your dependents will end if:

- » You are no longer eligible;
- » A dependent is no longer eligible (due to age, marriage, divorce, or loss of student status) unless he or she purchases continued coverage through COBRA or a court order requires continued coverage for eligible children;
- » You are in a specific class of employees that is no longer included in the plan; or
- » The plan is terminated.

Making Midyear Benefit Changes

Active and Retired Employees

Once enrolled in a plan, employees are generally barred from changing their enrollment except during an annual enrollment period. Nevertheless, changes may be made under the following circumstances:

- » Any employee who is enrolled in a closed panel plan and who changes his or her permanent residence to a location that is outside the service area of the plan may, by submitting a timely application to the District, change his or her enrollment to a plan that provides service in the area of his or her new permanent residence without a break in coverage. To be timely, the application for a change

in enrollment must be received by the District within 90 days after the employee established his or her new permanent residence.

- » Any employee who is enrolled in a closed panel plan and who, during an approved study, retraining or sabbatical leave of absence of 60 days or more, temporarily relocates to a location that is outside the service area of the plan may, by submitting a timely application to the District, temporarily change his or her enrollment to a plan that provides service in the area in which he or she will be temporarily located. To be timely, the application for a temporary change in enrollment must be received by the date on which the employee's leave commences.
- » Any employee whose enrollment in a plan is terminated at the request or option of the plan provider for any reason other than non-payment of premium may enroll in another plan without a break in coverage by submitting a timely application to the District. To be timely, the application for a change in enrollment must be received by the District within 90 days after the employee's enrollment was terminated.
- » Finally, any employee who has had a "qualified life event" as defined by Sections 125 and 129 of the Internal Revenue Code may change his or her eligible dependents by submitting a timely application to the District. To be timely, the application for a permissible "qualified life event" change must be received by the District within 31 days of the qualifying event.
- » If you experience a family status change, you must notify the LACCD Benefit Service Center to change your coverage within 31 days of the change in your status.

Part-Time Faculty

Once you enroll for coverage under the Premium Only Plan (POP), you may not change or cancel your benefits until the next annual enrollment period unless you have a family status change. Family status changes include:

- » Your marriage or divorce
- » The birth or adoption of a child;
- » The death of your spouse or child;
- » A change in your employment status that affects your eligibility for benefits;
- » Loss of coverage under another group insurance plan;
- » Loss of your spouse's eligibility under his or her employer's benefit plan; or
- » A change in a dependent child's eligibility, such as getting married, reaching the maximum age, or graduating from college

In addition, you have special enrollment rights that allow you to enroll yourself and your dependents for medical coverage in certain cases, even if you previously declined coverage. See “Special Enrollment Periods for Health Care Coverage,” on page 5, for more information.

If you experience a family status change, you must notify the LACCD Benefit Service Center to change your coverage within 31 days of the change in your status.

Women’s Health and Cancer Rights Act

Please be aware that all LACCD medical plans follow federal law when providing benefits for services related to a mastectomy. This law protects a patient’s right to the following medical care:

- » Reconstruction of the breast on which the mastectomy has been performed
- » Surgical reconstruction of the other breast to produce a symmetrical appearance
- » Prosthesis
- » Treatment of physical complications for all stages of mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes)

The plan will determine the course of treatment through consultation with you and your physician. As with other covered services under your medical plan, annual deductibles, copayments, and coinsurance may apply.

Newborns' and Mothers' Health Protection Act (Newborns' Act)

The Newborns' Act affects the amount of time you and your newborn child are covered for a hospital stay following childbirth. Group health plans, insurance companies, and health maintenance organizations (HMOs) that are subject to the Newborns' Act 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. However, the attending provider may decide, after consulting with you, to discharge you or your newborn child earlier. In any case, the attending provider cannot receive incentives or disincentives to discharge you or your child earlier than 48 hours (or 96 hours).