LUZERNE COUNTY COMMUNITY COLLEGE
2014-2015 BENEFITS WAIVER PLAN

July 2014

MEDICAL BENEFITS WAIVER PLAN ENROLLMENT

In September 1995, Luzerne County Community College qualified its cash exchange for medical insurance plan with the Internal Revenue Service (IRS). IRS Form Series 5500 has been completed and may be reviewed at your request.

Under this Plan, all eligible full-time employees of the College may reduce or waive coverage for the hospitalization, medical-surgical, major medical, dental and vision coverage offered in three available combinations. These include:

- Hospitalization, medical-surgical, major medical, dental and vision.
- Hospitalization, medical-surgical, major medical.
- Dental and/or Vision.

All eligible employees waiving health insurance benefits will be reimbursed 50% percent of the estimated annual premium cost of the affected coverage. Eligible employees not currently enrolled in a medical program would be reimbursed 50% percent of the estimated annual premium cost of their entitled coverage. Spouses both working full-time at the College may have one spouse enroll in an eligible benefit plan and the other spouse waive benefit insurance with reimbursement at 50% percent of the estimated annual premium cost of individual coverage.

Payment for waiver of health benefits will be made in two equal payments during the school year. One payment will be made on the first payday in December and the second will be made on the last payday of June in the subsequent school year. If you were hired after July 1 and elect to waive health benefits you will receive a prorated reimbursement.

To exercise this waiver of benefits you must submit a completed Benefits Waiver Enrollment Form (see pages 3 & 4 of this newsletter) to the College Office of Human Resources for approval. This Form must be completed in order to become or remain eligible for this Cash Benefit.

IMPORTANT REMINDERS

You are encouraged to share this "newspaper" Summary Plan Description and all the attendant information with your Spouse, your Family or anyone else you may look to for advice.

As with College's practice of administering choices for Blue Cross/Blue Shield Dental and Vision Plans, it is important that you make informed decisions so that this "Benefits Waiver Plan" will work for you.

To participate in the Benefits Waiver Plan, you must be eligible for medical insurance. In addition, you must complete the College's Benefits Waiver Enrollment Form. This Form is Pages 3 & 4 of the newsletter and can be detached from its perforated border.

Remember that your choices are unchangeable for one year, except in certain circumstances (see Page 2).

The Flexible Benefits Enrollment Form has been specially designed to make it easy to complete. However, if you do have a problem, contact the Human Resources Office at extension 7376.

CASH AS A BENEFIT - *CAN I REALLY TAKE THE MONEY?*

One of the common circumstances in a typical benefits program is that, in some circumstances, an employee may already have medical insurance, perhaps through a working Spouse or through some other means. Now, if such an Employee waives the College's Medical, Dental or Vision Plan, he/she will receive a cash lump sum payment. Can that be right?

Indeed, it can! Based on individual circumstances (e.g. coverage through your Spouse), it may be that you are able to maintain health coverage under another plan or subscribership and will not need the medical plan coverage offered under this Benefits Waiver Plan.

You can receive 50% of the estimated annual premium cost of the affected coverage. You should be aware that if you elect to waive health insurance in exchange for Cash, it will be subject to Federal Income Taxes, FICA, State and Local Taxes. Please pay special attention to the Benefits Waiver Plan Enrollment Form (Pages 3 & 4) if you are waiving the Medical Plan in favor of Cash. Item "E" will require that you supply Evidence of Other Medical Coverage as a strict condition for waiving the College-sponsored Medical Plan.

EMERGENCY REENROLLMENT IN THE COLLEGE HEALTH INSURANCE PLAN

If you must reenroll or newly enroll in the College Blue Cross/Blue Shield plan prior to a full year of disenrollment, due to loss of alternative medical coverage or other emergency circumstances, you may do so provided you contact the Human Resources Office immediately in writing. An emergency is defined as an unforeseen change in an individual's circumstance which necessitates the need for the individual to once again receive contracted benefits coverage through the College. The reinstatement into the school program will be effective on the first day of the month following notification of the need for such reinstatement. Appropriate payment will be made to said employee on a prorated basis for those months during that school year when coverage was not paid by the College.

YOUR PLAN RIGHTS UNDER ERISA

As a Public College, Luzerne County Community College is exempt from the jurisdiction of the Employee Retirement Income Security Act of 1974 (ERISA). However, the "Flexible Benefit Plan" is classified by the Department of Labor as a "welfare plan" and by IRS as a "specified fringe benefit plan" under IRCS. 6039(D). The Plan is referred to as a "flexible benefits" plan and is governed by IRC Sec. 125. Therefore, participants are entitled to certain protections and directions for recourse in the event of mistreatment by the Plan, its sponsor or administrator. Since these protections are essentially the same as ERISA, an ERISA rights Statement is published here for your information. The Plan Number (PN) assigned to the Flexible Benefit Account by LCCC is 510. You should refer to these numbers in any correspondence about the Plan. LCCC is designated as the Administrator for service of legal process in connection with claims under the Plan. Such process may be served by directing the process to the LCCC (EIN #23-1678363), 1333 S. Prospect Street, Nanticoke, Pa., 18634-3899, (570)740-0376.

ERISA RIGHTS STATEMENT

The Employee Retirement Income Security Act of 1974 (ERISA) was enacted to help assure that all employer-sponsored group benefits programs conform to standards set by Congress. An employee who is a participant in the Flexible Benefits Plan is entitled to certain rights and protections under ERISA, which provides that all participants will be entitled to (1) examine, without charge, at the Human Resources Office, all Plan documents and copies of documents filed with the U.S. Dept. of Labor, such as detailed annual reports and Plan descriptions; (2) obtain copies of all Plan documents and other Plan information upon written request to the Human Resources Office, subject to a reasonable charge for the copies; and (3) receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report. Plan records are kept on a plan year basis.

In addition to creating rights for Plan participants, ERISA imposes duties upon those responsible for the operation of a Plan who are called "fiduciaries" and who have a duty to operate the Plan prudently and in the interest of participants and beneficiaries. If a claim for a benefit under a Plan is denied in whole or part, the claimant must receive a written explanation of the reason for the denial. The claimant has the right to have the claim reviewed and reconsidered.

Under ERISA, there are steps an employee covered under a Plan can take to enforce the above rights. For instance, if the person requests materials and does not receive them within 30 days, the person may file suit in a Federal court. In such a case, the court may require LCCC to provide the materials and pay that person up to $100 a day until the person receives the materials, unless the materials were not sent because of reasons beyond LCCC's control.

CAN I MAKE CHANGES TO MY ELECTIONS?

Some may be allowed.

The Internal Revenue Service (IRS) says that eligible College employees may make elections to the plan once a year. However, what if your circumstances change? For example, suppose an employee is newly married, experiences the birth or adoption of a child, becomes divorced, or makes a benefit election based upon the coverage he/she maintains through a spouse's plan where they work and the spouse loses his/her job or coverage. What to do?

The Good News is that these types of circumstances will allow you to make changes at any time during the year in which they occur. So if you waive insurance coverage today based upon coverage through your spouse - but lose that coverage tomorrow - never fear! You can reenroll in the College's Plan on the very day you need to. However, **for any allowable changes, you must inform the Human Resources Office within 30 days of the event to avoid a lapse in coverage.** Changes which are requested due to a "change of mind" cannot be allowed until the next Enrollment Period.

For further information concerning plan changes, contact the Human Resources Office at extension 7376.

LUZERNE COUNTY COMMUNITY COLLEGE
Benefits Waiver Program
Enrollment Form
July 1, 2014 - June 30, 2015

A. **Name** _____
(Please Print)

Social Security# (last four digits only)_____

B. P**lease check the reason you are completing this form:**

[ ] 2014-2015 Plan Year Enrollment [ ] New Employee [ ] Change in Family Status

C. **Medical Waiver Plan Election.** Checked boxes indicate coverage waived.

Amounts are estimated annual reimbursements and are subject to change.

	Medical Dental & Vision	**Medical**	**Dental**	**Vision**
FACULTY, ADMINISTRATION & SECURITY				
Single	[ ] $5,108.28	[ ] $4,849.32	[ ] $228.06	[ ] $30.90
Parent & Child	[ ] $10,242.00	[ ] $9,659.52	[ ] $529.08	[ ] $53.40
Parent & Children	[ ] $11,473.68	[ ] $10,891.20	[ ] $529.08	[ ] $53.40
Husband & Wife	[ ] $12,544.86	[ ] $11,962.98	[ ] $529.08	[ ] $52.80
Family	[ ] $13,801.14	[ ] $13,194.66	[ ] $529.08	[ ] $77.40
Employee with LCCC Spouse	[ ] $5,108.28	[ ] $4,849.32	[ ] $228.06	[ ] $30.90
CLASSIFIED				
Single	[ ] $5,108.28	[ ] $4,849.32	[ ] $228.06	[ ] $30.90
Parent & Child	[ ] $10,242.00	[ ] $9,659.52	[ ] $529.08	[ ] $53.40
Parent & Children	[ ] $11,473.68	[ ] $10,891.20	[ ] $529.08	[ ] $53.40
Husband & Wife	[ ] $12,544.86	[ ] $11,962.98	[ ] $529.08	[ ] $52.80
Family	[ ] $13,801.14	[ ] $13,194.66	[ ] $529.08	[ ] $77.40
Employee with LCCC Spouse	[ ] $5,108.28	[ ] $4,849.32	[ ] $228.06	[ ] $30.90

D. **Benefit Waiver Allowance**

[ ] I elect to waive the Medical, Dental and/or Vision Plans and receive Cash. If waiving the Medical Plan coverage listed above, you must complete Item "E" and provide a copy of your current Identification Card.

[ ] I elect to terminate the Benefits Waiver Plan and reenroll in the College Medical Plan.

E. **Evidence of Other Coverage**

If you are waiving Medical Plan coverage, please complete the following inquiry about your replacement coverage:

Insurer/Plan_____ Policy # _____

Plan Sponsor (e.g. Employer) _____ _____

F. SIGNATURE REQUIREMENTS

In signing this form, I am stating that I understand all the provisions associated with the choice I have made, as described on this Form and in my Summary Plan Description (SPD), in electing between the Medical Insurance Plan(s) or the Benefits Waiver Allowance. I attest to the fact that my election was made of my own volition.

If I have waived participation in the Medical Insurance Plan for myself or my dependent(s), I attest that I maintain replacement medical/health plan coverage through another source, as indicated in Part "E" of this Form.

I recognize that in order to receive any remuneration for waiving participation my employer-sponsored medical plan, I must provide evidence of the replacement coverage on this form (Part E: "Evidence of Other Medical Coverage").

If I have elected the Benefits Waiver Allowance Option, I understand that applicable health and medical insurance costs incurred by myself and/or my dependents will be filed against the medical plan I have cited in Part "E" of the Form as "Evidence of Other Medical Coverage", in substitution for the Medical Plan offered by my employer. I further understand that by waiving my employer-sponsored Medical Plan, my coverage and that of my dependents will be subject to the terms and provisions of the insurer and plan sponsor cited as "Other Medical Coverage".

Furthermore, I understand that it is my responsibility before and throughout the term of my election indicated on this Form to determine and consider:

a) the fact that my replacement coverage is currently in force and will be for the duration of this agreement and that by requiring the identification and/or evidence of "other medical coverage", my employer is under no obligation to confirm or investigate the nature and extent of that coverage;

b) the fact that if I lose my "Other Medical Coverage" during the course of this agreement, it will be my responsibility to alert my employer of this fact and to reenroll in a Medical Plan offered by my employer, under the terms and provisions of Emergency Reenrollment, or risk becoming uninsured for health and medical expenses;

c) the fact that I may become subject to pre-existing medical condition benefit exclusions or reductions, or waiting periods for certain benefits, at the election of the employer-sponsored Medical Plan insurer/administrator or that my replacement coverage, if I waive Medical Plan Coverage at this time, but elect to reenroll in my employer-sponsored Medical Plan at a later date.

Therefore, I understand that any medical expenses I or my family incurs as a result of waiving this employer's medical plan coverage will be my and/or my family's sole responsibility. I hereby agree to indemnify and hold my employer harmless from and against all claims, causes of action, suits, demands, costs, expenses, including reasonable attorney's fees and litigation-related costs liabilities and losses, however caused, which may result or arise from my election of the cash settlement in lieu of medical plan coverage.

Furthermore, I authorize the attendant elections for the next 12 months and that I may not change this election but for a qualifying change in my family status, loss of medical coverage, or change in the employment of myself or my spouse.

I attest to the fact that the following information as provided by myself on this form as true and accurate to the best of my ability.

Signature _____ **Date** _____