M&G|exposure

INSIDE THIS ISSUE

BEN HOOVER NAMED IN TOP FORTY UNDER 40

Please help us in congratulating Sr. Employee Benefits Advisor, Ben Hoover, in being named one of this year's Pacific Coast Business Times Forty Under 40!

Ben is continually raising the bar at M&G and is always going the extra mile for his clients. This past year he became a Morris & Garritano shareholder, reinforcing his commitment to his clients and his coworkers.

Outside the office, Ben has been on the Partner Advisory Board for must! Charities since its inception and dedicates his time to helping raise funds for various projects including the Food Bank Coalition and The Boys and Girls Clubs. You might not know it, but Ben also has the unique skillset of being an auction ringman and is very active in the Jr. Livestock Auction at the Mid-State Fair among other charity auctions throughout our communities.

Ben truly cares for the well-being of his clients and their employees. The work that he and his team does allows for many in our community to have peace of mind regarding their healthcare.

Congratulations, Ben!

SPECIAL POINTS OF INTEREST

- Upcoming Seminars
- CA Minimum Essential Coverage Individual Mandate
- Cal/OSHA Urges Emergency Response Procedures
- Being Prepared with an EPLI
- Occurrence vs Claims Made Policies

HARASSMENT PREVENTION TRAINING UPDATE

Contributed by: Louise Matheny, Human Resources Consultant

On August 30, 2019, California Governor Gavin Newsom signed legislation (S.B. 778) amending the California Fair Employment and Housing Act by requiring employers with five or more employees to, **by January 1, 2021**, provide:

- At least two hours of classroom or other effective interactive training and education regarding sexual harassment to all supervisory employees in California; and
- At least one hour of classroom or other effective interactive training and education regarding sexual harassment to all nonsupervisory employees in California.

Thereafter, each covered employer must provide sexual harassment training and education to each employee in California once every two years. New nonsupervisory employees must be trained within six months of hire and new supervisory employees must be trained within six months of their assumption of a supervisory position.

The law also clarifies that an employer who has provided this training and education to an employee in 2019 is not required to provide refresher training and education again until two years thereafter. Additionally, beginning January 1, 2020, seasonal, temporary, or other employees that are hired to work for less than six months, must be provided sexual harassment training by their employer within 30 calendar days after hire date, or 100 hours worked — whichever is earlier.

The law took effect August 30, 2019.

UPCOMING SEMINARS

Contributed by: Louise Matheny, Human Resources Consultant

Labor Law Update – Best HR Practices for 2020
Presented by: Your People Professionals

Thursday, November 14th
7:15 am – 11:00 am
Santa Maria Country Club
505 W. Waller Lane, Santa Maria, CA 93455

Speaker: Jeff Dinkin, Stradling Law Firm

Registration: COMING SOON!

Save the date for the annual breakfast and comprehensive program on employment law developments. This event will help you stay on top of legislative and legal development to best protect your company against employment related liability.

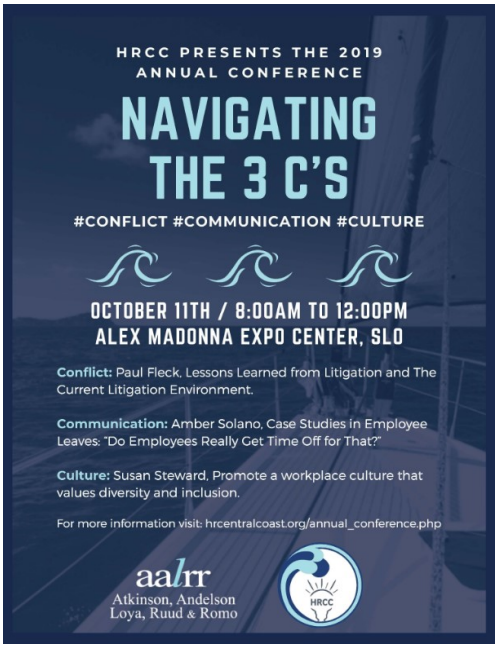
HRCC's Annual Conference
Navigating the 3 C's: #conflict #communication #culture
Presented by: Human Resources Association of the Central Coast

Friday, October 11
8:00 am - 12:00 pm
Alex Madonna Expo Center
100 Madonna Road, San Luis Obispo, CA 93405

Speakers: Paul Fleck, Amber Solano, and Susan Steward

Cost: $79 member or $89 non-member

Registration: Click here to register online

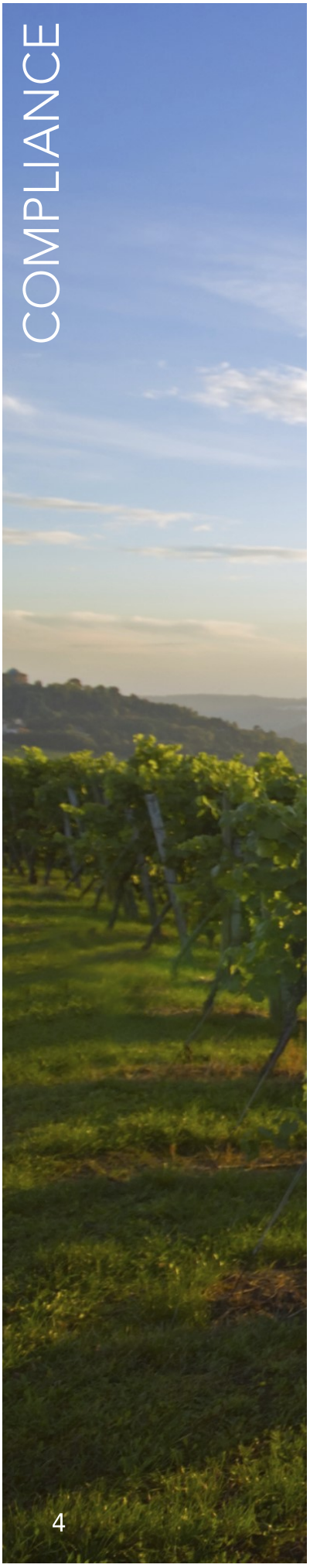


Conflict: Paul Fleck, Lessons Learned from Litigation and the Current Litigation Environment

Communication: Amber Solano, Case Studies in Employee Leaves: "Do Employees Really Get Time Off For That?"

Culture: Susan Steward, Promote a Workplace Culture That Values Diversity and Inclusion.

Morris & Garritano is proud to be a Major Sponsor for this conference



CA MINIMUM ESSENTIAL COVERAGE INDIVIDUAL MANDATE

Contributed by: Keith Dunlop, Director of Compliance and HR

On June 27, 2019, California Governor Gavin Newsom signed legislation (S.B. 78) creating the minimum essential coverage individual mandate. This mandate requires California residents to ensure that they, along with their spouses or dependents, are enrolled in and maintain minimum essential coverage for each month beginning on and after January 1, 2020. The California Health Benefit Exchange (Exchange), also known as Covered California, will grant exemptions from this mandate, based on hardship or religious conscience, and will establish a process for determining exemption eligibility. The law also imposes an **individual shared responsibility penalty** for the failure to maintain minimum essential coverage, to be determined and collected by the California Franchise Tax Board (FTB), in collaboration with the Exchange. The FTB will provide the Exchange with information about individuals who do not maintain the minimum essential coverage, and as a result, the Exchange will conduct annual outreach and enrollment efforts with those individuals.

Applicable entities that provide minimum essential coverage to an individual must also file specified returns with the FTB regarding the coverage. An applicable entity is:

- A carrier licensed or otherwise authorized to offer health coverage with respect to minimum essential coverage, including coverage in a catastrophic plan, that is not described in bullet three or four.
- An employer or other sponsor of an employment-based health plan with respect to employment-based minimum essential coverage.
- The State Department of Health Care Services and county welfare departments with respect to coverage under a state program.
- The Exchange with respect to individual health plans, except catastrophic plans, on the Exchange.

Of note, Covered California defines minimum essential coverage as “[t]he type of health insurance coverage that an individual must have in order to comply with the individual mandate set forth by the federal Affordable Care Act (ACA).”

The law took effect on June 27, 2019.

FEATURED VIDEO: BENEFITS KEY TERMS EXPLAINED

Contributed by: Luzette Graves, Medical Case Manager

Premiums? Deductibles? Copays? All these different terms and components to medical plans are confusing. So, what does it all mean and why do you need to know?

Insurance jargon can make you feel like you're sitting in the back seat of a taxi in a foreign country. How do you know if you're being taken on a wild, roundabout, and expensive ride when what you really want is the shortest, most cost-effective path to good health and wellbeing? Today's medical insurance market offers a maze of options to meet our society's demand for choice and customization and with that comes differences in the price you pay for each component of your plan. If you understand how each of the different components works and how they interact over the course of the calendar year, you will be able to quickly decide which of the options available has the right combination of convenience, quality of care, and affordability for you and your family.

In other words, understanding a few basic concepts is all you need to determine how much you will pay each step of the way. Getting clarity on the basic structure of medical plans allows you to easily compare the options and evaluate them based on your personal priorities and preferences. With this basic knowledge, you can turn the medical insurance maze into a straightforward decision-making tool that empowers you to confidently compare plans and choose the best option available for you and your family.

Put yourself in the driver's seat by watching our quick educational video, Benefits Key Terms Explained.

This video is also available in Spanish, Términos Clave de Seguro Médico Explicados.

For more educational videos on employee benefits and healthcare, check out our full Benefits Video Library, in both English and Spanish.

CAL/OSHA URGES EMERGENCY RESPONSE PROCEDURES

Contributed by: Michael Schedler, Loss Control Analyst

As a result of an increase in the number of “unknown” causes of workplace deaths, the Division of Occupational Safety and Heath has started investigating dozens of cases that might be related to heat illness.

So far in 2019, there have not been any confirmed heat-related fatalities. However, there are cases still under investigation. With a series of heat waves hitting the state, Cal/OSHA is urging employers to implement emergency response procedures, which should include:

- An effective means of contacting supervisors or emergency medical services when necessary;
- How to respond to signs and symptoms of heat illness, including first aid measures and how emergency services will be provided;
- How to contact EMS and how to transport employees to a place they can be reached by EMS; and
- An effective way to provide clear and precise directions to emergency responders.

WHAT TO EXPECT FROM AN OSHA VISIT

Contributed by: Michael Schedler, Loss Control Analyst

A visit from OSHA is probably not how anyone wants to start their day. However, being prepared and organized with a plan can make a big difference when an inspector shows up at your office or jobsite. In fact, an inspector’s report has a place to record an employer’s level of cooperativeness – so a positive, prepared attitude never hurts.

So, what can you expect from an OSHA inspection? Here are a few highlights of the process – from what triggers an inspection to the closing conference.

Why Is OSHA at Your Doorstep?

While there are several scenarios that may prompt an investigation, the most priority items are:

- Imminent danger situations and fatalities;
- Severe injuries or illnesses;
- Worker complaints;
- Referrals of hazards from other federal, state or local agencies; individuals; organizations; or media outlets; or
- Programmed inspections, including those that fall under an OSHA emphasis program.

Always Being Prepared

Receiving advanced notice of an inspection is rare, so it is best to always be prepared by having safety and training programs in place along with an emergency action plan and a hazard communication program. Being able to provide injury and illness logs dating back at least three years and personal protective equipment hazard assessments for the last five years will also be helpful.

OSHA inspections can be stressful, so it is best to designate a representative from your organization who will remain level-headed and friendly throughout the process. Knowing who is in charge of gathering any documents, how the company will correct small hazards, and including a union representative in the inspection (if applicable) are all important elements to a proper plan.

WHAT TO EXPECT FROM AN OSHA VISIT (CONT'D)

Contributed by: Michael Schedler, Loss Control Analyst

There have been reports of scammers posing as OSHA inspectors and requesting payment of fines during an inspection. To prevent this from happening, you are always within your rights to check an OSHA inspector's credentials or call the local OSHA office or the Department of Labor office of the Inspector General to confirm.

During an Inspection

At the opening conference, the compliance safety and health officer (CSHO) will provide the reason for the inspection as well as an explanation of the scope of the inspections and the procedures for the walkthrough. Any hazard in plain sight during the walkthrough may be investigated, even if it wasn't part of the initial inspection.

During the walkthrough, the inspector will likely take notes and pictures. These will not be shared with the employer, so you may want to mirror their actions to have your own documentation and don't be afraid to ask questions.

An OSHA inspector may ask to interview a random selection of employees. The interviews should only take a few minutes, and it is best to have a designated location where they can take place. If a translator is needed, OSHA will provide that service via a headset or phone.

Closing Conference

A closing conference will take place after the walkthrough, generally over the phone one to six weeks after the inspection. The CSHO will disclose their findings, any violations, corrective actions, and reasonable timelines to make those corrections. Prompt corrections may help the employer qualify for OSHA's Quick-Fix Penalty Reduction program, but only for certain violations.

If citations or fines are issued, they are not official until they are reviewed by an area office and the employer receives notice by certified mail. A copy of this notice must be posted "near the place where each violation occurred to make employees aware of the hazards to which they may be exposed." Upon receipt, the employer has 15 business days to request a conference with the area director where they can show corrective actions have been made. This may reduce or void their penalties.

The best practice is to simply be prepared and don't try to fake your way through an inspection. Following procedures, making documentation, and being cooperative will make a stressful situation a little less stressful.

Source: https://www.safetyandhealthmagazine.com/articles/18400-what-to-expect-when-osha-is-inspecting

BEING PREPARED WITH EPLI

Contributed by: Adam Peterson, Commercial Risk Advisor

In the recent storm of sexual harassment allegations in mainstream entertainment and media, there is an anticipated wave of employment practices liability insurance (EPLI) claims to follow throughout other industries.

This recent surge represents a tipping point – from a point where employees feared retaliation to one where they feel empowered to speak out regardless of the consequences. Typically, these claims will often initial a trickle-down effect throughout organizations.

The likelihood of an employer being hit by a discrimination charge of any kind is higher than employers may realize – at least 10%. These employment charges are often the first step toward employment suits and are based on race, sex, disability, age, national origin, religion, color, or sexual harassment. Nearly half of all these charges also stem from retaliation.

From a risk management perspective, now is the time to review your own company's EPLI coverage. Some policies today have specific wording meant to narrow the scope of covered claims – and those policies would drive a clear distinction between behavior that is insurable versus behavior that is so egregious that to insure it would be offensive or outright against public policy. This might include wording such as covering "everything except harassment that is deemed licentious or immoral or sexual abuse or exploitation or abuse of a child."

The likelihood of an employer being hit by a discrimination charge of any kind is higher than employers may realize – at least 10%.

The language is different for every policy, but some typical language is "fact, circumstance, situation, or event that reasonably would be regarded as a basis for a claim." That language being imprecise is abundant ground for factual disputes as to when a company should have known that a claim was likely based on the knowledge they had at the time.

So, while the recent surge in sexual harassment allegations has not yet translated into claims, it's only a matter of time before the EPLI claims start surfacing. When they do, it is important to have proper EPLI coverage in place.

OCCURRENCE VS. CLAIMS MADE POLICIES

Contributed by: Heather Ross, Claims Advocate

Liability policies are typically written on either an “occurrence” or a “claims made” basis, and it’s important to understand the difference. Failure to report a claim (or even a potential claim) according to the reporting provisions in the policy can potentially provide grounds for an insurer to disclaim coverage for the loss, even when the claim would otherwise be covered.

Most, but not all, commercial general liability policies are written on an “occurrence” basis. An occurrence policy covers claims that arise out of damage or injury that took place during the policy period, regardless of when the claim is made. This means that if a customer falls on your premises, but you don’t hear about it until two years later when she files a lawsuit, the general liability policy that was in force at the time of the accident is the one that will respond to the claim.

In contrast, most specialty policies — including Professional Liability, Employment Practices Liability (EPL), and Directors and Officers Liability (D&O) — are written with a “claims made” coverage trigger, which means that the claim must be first made against the insured during the policy period for coverage to apply. For example, if you terminate an employee without incident, and then nine months later he files a complaint with the DFEH against you, the claim is considered to have been made at the time the complaint is filed, and the EPLI policy currently in force is the one to which the claim should be reported.

Most claims-made policies require that claims made during the policy period must also be reported during the policy period. For that reason, even if you’re not sure whether a situation constitutes a “claim,” you’re generally better off putting the company on notice to preserve your right to any potential coverage under the policy.

If you submit notice of a potential claim, and the insurer determines that there’s enough detail to believe a claim will later be presented, they can accept the matter as a “notice of circumstance” or a “notice of potential claim.” This then serves as a placeholder or bookmark on that policy, signifying that you’ve complied with the reporting requirements, and that the policy is positioned to respond to a future claim, should one be presented — even after the policy expires!

Even if you’re not dealing with the strict reporting provisions of a claims-made policy, all policies include the duty to promptly notify the insurer of potential claims, so if something’s happened, and you’re not sure what to do, please give our office a call; we’re happy to advise you.

WHAT IS A WORK STATUS REPORT? DO I NEED A COPY?

Contributed by: Mary Jean Collins, Workers’ Compensation Claims Analyst

When you refer your injured employee to an Urgent Care for treatment, they will be given a Work Status Report or a Return to Work slip. This document provides information that you, as the employer, are entitled to know. The report includes findings regarding an employee’s diagnosis, work restrictions, and when their next appointment is scheduled. In some cases the provider will also note if the employee is referred for physical therapy, X-rays, an MRI, or specialist consult.

We always recommend you let your employee know that they must provide you with a work status report or return to work slip before they will be permitted to return to work.

It is important to make sure your employee provides you with a Work Status Report after each appointment. Occasionally the employee does not return to work after the appointment, in which case you should contact the provider and have them fax or email you a copy of the release. In situations where the employee is referred to a specialist, the provider many not always provide a release to the employer, but you can obtain this information from your claims examiner assigned to the claim.

The information on a Work Status Report is important to you for multiple reasons:

1. If the employee is placed off work, the document can be used to authorize an absence.
2. If the employee is released with restrictions, you can determine if you are able to make accommodations that allow the employee to return to work.
3. It is the best way to keep track of the progress on a claim.

If you have any questions regarding Work Status Reports or any other Workers’ Compensation issues, please contact Mary Jean Collins.

M&G EVENTS

M&G NAMED A BEST PRACTICE AGENCY

M&G has been selected for the fourth year in a row to be part of an elite group of independent insurance agencies around the United States participating in the Independent Insurance Agents & Brokers of America (IIABA or the Big "I") "Best Practices" Study Group.

Only 267 independent agencies throughout the U.S. qualified for inclusion in the 2019 Best Practices Study. More than 1,300 agencies were nominated and evaluated based on outstanding customer retention, growth, stability and financial management.

We are proud to maintain our Best Practices standing and to continually provide the best service possible for our clients.

San Luis Obispo
1122 Laurel Lane
San Luis Obispo, CA 93401

Phone: 805-543-6887
Fax: 805-543-3064

Santa Maria
2721 Santa Maria Way
Santa Maria, CA 93455

Phone: 805-361-1750
Fax: 805-361-1728

E-mail:
info@morrisgarritano.com

MORRIS & GARRITANO INSURANCE

With a tradition of excellence in insurance services since 1885, we offer all lines of business and personal coverage with a staff of over 120 professionals.

Our monthly newsletter is where you can find informative articles relating to the Commercial Lines and Employee Benefits industries.

For day-to-day updates and more information about our community and our company, follow us on Facebook, Twitter, Instagram, or LinkedIn. Visit our website or check us out on Yelp!

Please contact us for more information or questions on anything mentioned in this newsletter.