

PASSPORT TO WELLNESS

2027 BENEFITS GUIDE

January 1st - December 31st, 2027

**Grab your guide and get ready for your
benefits enrollment journey!**



GROSSMONT-CUYAMACA
COMMUNITY COLLEGE DISTRICT

Eligibility

Grossmont-Cuyamaca Community College District assures an affordable and comprehensive benefits package which includes fully paid medical, dental, vision and life coverage for the employee. Employees have the option to enroll their dependents in a medical or dental plan.

Employees also have the opportunity to participate in a variety of voluntary benefits that can be funded by convenient payroll deductions including:

- Disability
- Life/Accidental Death & Dismemberment
- Accident/Cancer/Critical Illness
- Flexible Spending Accounts
- Legal Plans

Eligible Employees

Regular, full- or part-time staff and contract faculty who work 20 or more hours per week are eligible for the District's benefits on the first of the month following your contract date of hire provided you meet the minimum eligibility guidelines as defined by the District.

Adjunct Faculty are eligible for medical, dental, and vision coverage immediately following two consecutive semesters maintaining a .40 (40%) FTEF

Eligible Dependents

You may enroll your eligible family members in the same medical, dental, and/or vision plans you choose for yourself. Eligible family members include:

- Your legally married spouse
- Your registered domestic partner
- Your children under the age of 26 who are your biological children, stepchildren, adopted children or children for whom you have legal custody
- Your disabled children, age 26 or older who meet certain criteria, may continue health coverage
- Children of registered domestic partners

Proof of Dependent Eligibility

It is mandatory employees submit documentation verifying that the individuals enrolled in benefits meet the eligibility requirements. Acceptable documents include:

- Certified copy of a marriage certificate
- Declaration of Domestic Partnership form
- Birth or adoption/court-appointment guardianship certificate
- First page of current or previous year's tax form

End of Eligibility

Eligibility ends for you and/or your dependent(s) on the first of the month following the date of termination of your employment or reduction in hours which causes you to lose eligibility, your divorce/legal separation, your covered child's 26th birthday or death.

Waiving Medical Coverage

Employees can opt-out of enrolling in a medical plan. Opt-outs are available with initial eligibility elections, Open Enrollment, or within 31 days of enrollment in a qualified external medical plan. Proof of alternative medical coverage must be provided in order to qualify for the waiver. Please contact the Benefits team for next steps or to ask questions.

Enrollment

When to Enroll

The choices you make when you first become eligible will remain in effect for the remainder of the calendar year. These are your three opportunities to enroll or make changes to your benefit elections:

1. Within 31 days of your initial eligibility date
2. During the annual Open Enrollment period
3. Within 31 days of a qualified change in family status

Newly Eligible Employees

Employees who are newly eligible for benefits will be assigned enrollment tasks in Workday. You will also receive an enrollment email from our Benefits Team.

Enrollment Checklist

- ☐ Take some time to learn about all of the benefit options that are available to you. Read this 2027 Employee Benefits Guide carefully as you consider your plan choices.
- ☐ Attend a benefits webinar to better understand the details of the health plan choices, get an overview of all the benefit programs, and have an opportunity to ask questions.
- ☐ Decide if you want to enroll in a Flexible Spending Account (Healthcare and/or Dependent Day Care). Remember: you must actively enroll each year!!!
- ☐ Actively enroll online through Workday within 31 days of your initial eligibility date, during the open enrollment period, or within 31 days of a qualified change in family status.
- ☐ Review your beneficiary(ies). Make any necessary updates to ensure the accuracy of your beneficiary information for Life/AD&D insurance.
- ☐ Once you have completed your enrollment through Workday, save or print a copy of your confirmation statement, review it for accuracy, and retain it for your records.
- ☐ The Benefits Team will not mail confirmations to your home address. This is your only record of your enrollment.

Open Enrollment

During the District's annual open enrollment, employees have the opportunity to enroll or change your benefit elections for the upcoming plan year. Employees should review your benefit plan options, verify your personal information and make any necessary changes. Changes made during open enrollment will become effective on January 1st of the following year. It is important to note that once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

Qualifying Events - Making Mid-Year Benefit Changes

IRS rules prohibit changes during the year unless you have a qualifying event. Some examples of qualifying events are:

- Change in marital status including marriage, death, divorce, legal separation, or annulment
- Change in number of dependents (birth, adoption, death)
- Change in employment status that changes eligibility status: (termination, or decrease in hours worked, etc.)
- Change in residency that affects access to providers
- Change in spouse or child's eligibility under another employer or government plan
- Open enrollment of spouse's employer's plan

IMPORTANT REMINDER: You are responsible for notifying the Benefits Department within 31 days of any qualifying life event that would cause a change in benefit status including a COBRA eligibility change.

Medical Benefits

Choosing the Right Medical Plan

We understand that selecting a medical plan for you and your family is an important decision that involves balancing the premium cost with other details like access to doctors and out-of-pocket expenses like copays and coinsurance.

Because employees have different needs, the District offers several medical plan options through CalVEBA which provide flexibility for employees to select plans that most fit your budget and lifestyle needs.

Know Your Options

Employees will have the choice to enroll in one of the 5 medical plans offered through Kaiser, United Healthcare, or SIMNSA which include:

- Kaiser HMO
- UHC Harmony HMO
- UHC Alliance HMO
- VEBA Direct HMO
- SIMNSA Cross-Border HMO

Important! Starting January 1, 2027 the *UHC Harmony* plan will no longer support UCSD Medical Group or UCSD-affiliated providers. Employees who utilize UCSD should select either the UHC Alliance plan or the VEBA Direct HMO plan.

UHC HARMONY NETWORK

Sharp Community Medical Group
Sharp Rees-Stealy Medical Group
Inc. SCMG Arch Health Partners
(Sharp) Optum Care

UHC ALLIANCE NETWORK

Greater Tri-Cities IPA
Mercy Physician Medical
Group Optum Care
Rady Children's Health
Scripps Coastal Medical
Center Scripps Physician
Medical Group Scripps Clinic
UCSD Medical Group

VEBA DIRECT NETWORK

Sharp Community Medical Group
Sharp Rees-Stealy Medical Group
Inc. Rady Children's Health
UCSD Medical Group
UCSD Medical Group Affiliates

Kindbody Benefits

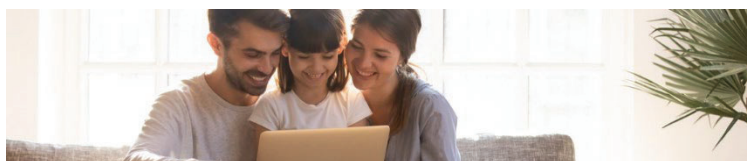
Starting January 1, 2027, Kindbody will have expanded access for CalVEBA members, including Kaiser members!!

- Core fertility care
- Virtual menopause support
- Holistic support sessions
- KindMan
- KindDoula
- Cryopreservation services

Chiropractic & Acupuncture

In partnership with Optum, VEBA offers a chiropractic and acupuncture benefit.

- You'll have access to a network of 3,000 high-quality network providers offered by OptumHealth Physical Health of California
- Unlimited visits (subject to medical necessity)
- Copays align with your PCP office visit copay
- You must receive care from participating Optum providers. Before you receive services, please verify that your chiropractor or acupuncturist still participates with Optum



Learn more about your Chiropractic and Acupuncture benefits at:

www.myoptumhealth-physicalhealthofca.com

1-800-428-6337 (Monday -Friday, 5:00 a.m. - 5:00 p.m.)

Kaiser HMO

Kaiser Permanente's integrated health care delivery model is made up of the health insurance plan, doctors, hospitals, labs, and pharmacies all within one organization. Within the Kaiser environment, members have the convenience of a one stop shopping experience because most facilities feature all of these components in one location.

Medical information is readily available when needed because all facilities are connected. A patient's medical records, their physicians, and pharmacies are all electronically linked which also saves time and makes navigating health care easy.

Services are covered if they are provided, prescribed or authorized by a Kaiser Plan Physician and you receive the services from Plan Providers inside the Southern California Region Service Area (your Home Region), except in the event of an emergency specifically noted to the contrary in the Evidence of Coverage (EOC).

Kaiser HMO

Deductible & Maximum OOP:

Annual Deductible	\$0
Out-of-Pocket Max (Ind/Fam)	\$1,500/ \$3,000

Hospital Services

Hospitalization	No Charge
Mental Health / Substance Abuse	No Charge
Outpatient Surgery	\$15

Emergency & Urgent Care

Ambulance Services	No Charge
Emergency Room (waived if admitted)	\$100
Urgent Care	\$15

Preventative Care

Routine Physical Maintenance Exams	
Well Baby/Child Exams	No Charge
Immunizations	

Diagnostic Testing

Lab tests / diagnostic x-ray	
MRI, most CT and PET Scans	No Charge

Outpatient Physician Services

Office Visits (PCP/Specialist)	\$15
Physical & Rehab Therapy	\$15
Mental Health / Substance Abuse	\$15

Other Services/Equipment

Durable Medical Equipment	
Home Health (up to 100 visits per year)	No Charge
Hospice	

Prescriptions (30-day Supply; Retail Pick Up)

Generic Drugs (Tier 1)	\$10
Brand Drugs (Tier 2)	\$25
Specialty Drugs (Tier 4)	\$50

Chiropractic / Acupuncture

Provided through OptumHealth	\$15
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United Healthcare Harmony HMO

The United Healthcare Harmony HMO plan offer members medical care through physicians and facilities in the Harmony network.

The Harmony plan delivers a personalized, convenient, and simplified care experience. It focuses on the physician-patient relationship by following a best-practice model, designed to improve health outcomes and efficiency.

Upon enrolling in the UHC Harmony plan, you must choose a primary care physician (PCP) from the Harmony network. Your PCP will coordinate your care, including referrals to specialists. Covered family members can select different PCPs and/or medical groups within the network. Members may also change PCPs or medical groups within the network during the year.

The following summary highlights the covered benefits under the United Healthcare Harmony HMO plan.

United Healthcare Harmony HMO

Deductible & Maximum OOP:

Annual Deductible	\$0
Out-of-Pocket Max (Ind/Fam)	\$1,500/ \$3,000

Hospital Services

Hospitalization	No Charge
Mental Health / Substance Abuse	No Charge
Outpatient Surgery	\$15

Emergency & Urgent Care

Ambulance Services	No Charge
Emergency Room (waived if admitted)	\$100
Urgent Care	\$10

Preventative Care

Routine Physical Maintenance Exams	
Well Baby/Child Exams	No Charge
Immunizations	

Diagnostic Testing

Lab tests / diagnostic x-ray	
MRI, CT, and PET Scans	No Charge

Outpatient Physician Services

Office Visits (PCP/Specialist)	\$10
Physical & Rehab Therapy	\$10
Mental Health / Substance Abuse	\$10

Other Services/Equipment

Durable Medical Equipment	
Home Health (up to 100 visits per year)	No Charge
Hospice	

Prescriptions

See Pharmacy Benefits Page

Chiropractic / Acupuncture

Provided through OptumHealth	\$10
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United Healthcare Alliance HMO

The United Healthcare Alliance HMO plan offer members medical care through physicians and facilities in the Alliance network.

The Alliance HMO plan allows access to a distinct network of quality rated physician groups who will work with you to make informed decisions about your health and help you save money.

Upon enrolling in the UHC Alliance plan, you must choose a primary care physician (PCP) from the Alliance network. Your PCP will coordinate your care, including referrals to specialists. Covered family members can select different PCPs and/or medical groups within the network. Members may also change PCPs or medical groups within the network during the year.

The following summary highlights the covered benefits under the United Healthcare Alliance HMO plan.

United Healthcare Alliance HMO

Deductible & Maximum OOP:

Annual Deductible	\$0
Out-of-Pocket Max (Ind/Fam)	\$3,000 / \$6,000

Hospital Services

Hospitalization	\$500
Mental Health / Substance Abuse	\$500
Outpatient Surgery	\$200

Emergency & Urgent Care

Ambulance Services	No Charge
Emergency Room (waived if admitted)	\$150
Urgent Care	\$20

Preventative Care

Routine Physical Maintenance Exams	
Well Baby/Child Exams	No Charge
Immunizations	

Diagnostic Testing

Lab tests / diagnostic x-ray	No Charge
MRI, CT, and PET Scans	\$200

Outpatient Physician Services

Primary Care Office Visit	\$20
Specialist Care Office Visit	\$30
Physical & Rehab Therapy	\$20
Mental Health / Substance Abuse	\$20

Other Services/Equipment

Durable Medical Equipment	
Home Health	No Charge
Hospice	

Prescriptions

See Pharmacy Benefits Page

Chiropractic / Acupuncture

Provided through OptumHealth	\$20
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VEBA Direct HMO

The VEBA Direct HMO plan offer members medical care through physicians and facilities in the VEBA Direct network.

The VEBA Direct HMO plan is a model built with new, innovative components developed for better cost management, financial flexibility, more engaging collaboration with medical groups, greater transparency, and lower administrative costs.

Upon enrolling in the VEBA Direct plan, you must choose a primary care physician (PCP) from the VEBA Direct network. Your PCP will coordinate your care, including referrals to specialists. Covered family members can select different PCPs and/or medical groups within the network. Members may also change PCPs or medical groups within the network during the year.

The following summary highlights the covered benefits under the VEBA Direct HMO plan.

VEBA Direct HMO

Deductible & Maximum OOP:

Annual Deductible	\$0
Out-of-Pocket Max (Ind/Fam)	\$2,500 / \$5,000

Hospital Services

Hospitalization	\$250
Mental Health / Substance Abuse	\$250
Outpatient Surgery	No Charge

Emergency & Urgent Care

Ambulance Services	No Charge
Emergency Room (waived if admitted)	\$150
Urgent Care	\$20

Preventative Care

Routine Physical Maintenance Exams	
Well Baby/Child Exams	No Charge
Immunizations	

Diagnostic Testing

Lab tests / diagnostic x-ray	No Charge
MRI, CT, and PET Scans	\$100

Outpatient Physician Services

Office Visits (PCP/Specialist)	\$20
Physical & Rehab Therapy	\$20
Mental Health / Substance Abuse	\$20

Other Services/Equipment

Durable Medical Equipment	
Home Health	No Charge
Hospice	

Prescriptions

See Pharmacy Benefits Page

Chiropractic / Acupuncture

Provided through OptumHealth	\$20
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SIMNSA Cross-Border HMO

Sistemas Medicos Nacionales, S.A. de C.V. (SIMNSA) is a licensed HMO plan authorized to contract with California employers to provide health benefits and services in Mexico. SIMNSA is one of the leading HMO programs in Northern Mexico and was the first Mexican HMO to be licensed as a health care service plan by the State of California.

The networks extend through the border cities of Tijuana, Tecate, and Mexicali. They feature affordable and culturally sensitive health care.

SIMNSA Cross-Border HMO

Deductible & Maximum OOP:

Annual Deductible	\$0
Out-of-Pocket Max (Ind/Fam)	\$6,350 / \$12,700

Hospital Services

Hospitalization	No Charge
Mental Health / Substance Abuse	No Charge
Outpatient Surgery	\$15

Emergency & Urgent Care

Ambulance Services	No Charge
Emergency Room (waived if admitted)	\$250
Urgent Care	\$50 US Visit / \$25 Mexico Visit

Preventative Care

Routine Physical Maintenance Exams	
Well Baby/Child Exams	No Charge
Immunizations	

Diagnostic Testing

Lab tests / diagnostic x-ray	
MRI, CT, and PET Scans	No Charge

Outpatient Physician Services

Office Visits (PCP/Specialist)	\$5
Physical & Rehab Therapy	\$10
Mental Health / Substance Abuse	\$5

Other Services/Equipment

Durable Medical Equipment	
Home Health	No Charge
Hospice	

Prescriptions

Generic Drugs	
Brand Drugs	\$5
Specialty Drugs	

Chiropractic / Acupuncture

Not Covered under the SIMNSA HMO

Prescription Drugs

United Healthcare Members



The United Healthcare medical plans include a prescription drug benefit for enrolled members with access to thousands of convenient retail pharmacies nationwide including grocery, discount, and drug stores. VEBA has partnered with Express Scripts for pharmacy benefits.



PRESCRIPTION BENEFITS



Carrier/Benefit	How to Contact
EnGuide Pharmacy The Express Scripts program now features EnGuide Pharmacy, a new home delivery pharmacy focused on only dispensing GLP-1 drugs. This new pharmacy is staffed by clinicians with specialized knowledge in GLP-1 drugs.	Call: 800-282-2881 Visit: Express-scripts.com/EnguidePharmacy
EnReachRx Offered through Express Scripts, this high-touch patient solution facilitated through retail pharmacies ensures reliable access to GLP-1 medications while providing clinical support, dose optimization, and side effect management.	Call: 800-282-2881 Visit: Express-scripts.com/EnguidePharmacy
Express Scripts This pharmacy benefits manager helps improve prescription care and manage health care costs for GLP-1 Diabetes & weight management medications.	Call: 800-918-8011 Visit: Express-scripts.com/

Medical Plan Name	United Healthcare Harmony HMO	VEBA Direct HMO	United Healthcare Alliance HMO	Kaiser HMO	SIMNSA Cross-Border HMO
Rx Deductible	None	None	None	None	None
Maximum (Individual/Family)	Combined with Medical	Combined with Medical	Combined with Medical	Included in Medical	Included in Medical
Rx Formulary List	National Preferred	National Preferred	National Preferred	Kaiser	SIMNSA
Rx Pharmacy Network	Express Advantage Network (EAN)	Express Advantage Network (EAN)	Express Advantage Network (EAN)	Kaiser	SIMNSA
Short Term Prescription Drugs (Up to 30-day supply)	Generic \$5	Generic \$10	Generic \$10	Generic \$10	Generic \$5
	Preferred \$25	Preferred \$25	Preferred \$30	Preferred \$25	Preferred \$5
	Non-Preferred 50%, \$175 max	Non-Preferred 50%, \$175 max	Non-Preferred 50%, \$175 max	(up to 30 day supply)	
Long Term Prescription Drugs (Up to 90-day supply)	Generic \$10	Generic \$20	Generic \$20	Generic \$20	Generic N/A
	Preferred \$50	Preferred \$50	Preferred \$60	Preferred \$50	Preferred N/A
	Non-Preferred 50%, \$350 max	Non-Preferred 50%, \$350 max	Non-Preferred 50%, \$350 max	(up to 100 day supply)	

Prescription Drugs

Kaiser Members

Your provider may order a prescription for you during your appointment. In most cases, it will be sent to our pharmacy electronically, and you may choose from several convenient ways to receive your prescriptions.

- Mail order home delivery (usually 3 to 5 days) on most prescriptions at no additional cost
- Pharmacy pick up
- Same or next day delivery

Mail order home delivery refills

Kaiser's mail-order pharmacy offers a convenient way to refill most of your prescriptions. Not all prescriptions can be mailed as restrictions apply.

Visit kp.org/refill or access the KP mobile app to order refills and check the status of your orders. If it's your first time placing a refill order online, please create an account by visiting kp.org/register.

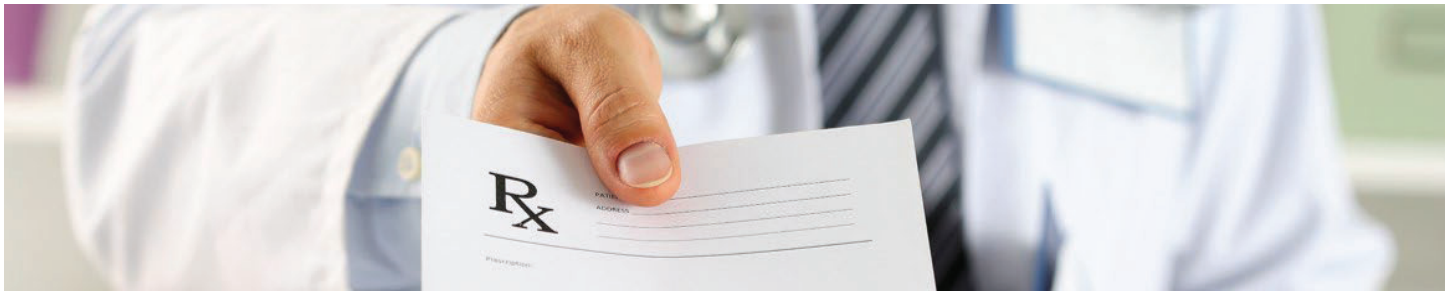
Same-day or next-day home delivery is available in most areas and for most prescriptions for an additional fee. Order using the Kaiser Permanente app, kp.org/homedelivery, or call 1-877-761-4091. Some exclusions apply.

Have questions?

Please call the pharmacy number printed at the top of your prescription label. For information about your benefits, call Member Services, 24 hours a day, 7 days a week (closed holidays) at 1-800-464-4000.

Out of refills?

If you don't have any prescription refills left when you place an order, we can request refills from your provider. If approved, please allow 2 business days for us to process your order.



Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check the health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a Formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into categories or tiers. These groupings range from least expensive to most expensive cost to you. "Preferred" drugs usually cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug counterparts.

The Formulary Drug Tiers Determine Your Cost

\$	Preferred Generic Drug
\$\$	Non-Preferred Generic Drug
\$\$\$	Preferred Brand Name Drug
\$\$\$\$	Non-Preferred Brand Name Drug
\$\$\$\$\$	Specialty Drug

To find out if a drug is on your plan's formulary, visit the plans website or call the customer service number on your ID card.

Virtual Care

United Healthcare and Kaiser members have access to telehealth services as part of your medical plan. Get the care you need – including most prescriptions – for a wide range of minor conditions. You can connect with a board-certified doctor via secure video chat or phone, without leaving your home or office. When, where and how it works best for you!

United Healthcare

As a UHC member, you have access to Teladoc's national network of board-certified physicians, licensed in California. Whenever you need care, Teladoc doctors are available 24/7 by phone or video.

Use Teladoc	Get the care you need	Meet the doctors
▪ If you're considering the ER or urgent care center for a non-emergency ▪ When on vacation, a business trip, or away from home ▪ For short-term prescription refills 	Teladoc doctors can treat many medical conditions including: ▪ Cold and flu symptoms ▪ Allergies ▪ Bronchitis ▪ Respiratory infection ▪ Sinus problems ▪ And more	All Teladoc doctors: ▪ Are practicing primary care physicians, pediatricians, and family physicians ▪ Have an average of 20 years of experience ▪ Are board certified and licensed ▪ Are credentialed every three years

Talk to a doctor anytime for minimal copays!

- \$0 copay for many virtual services
- For all others, matches your PCP copay

Get started with Teladoc

1. Set up account at www.teladoc.com/medical-experts
 2. Provide medical history
 3. Request a consult
- Call Teladoc at 1-800-Teladoc (835-2362) for help. Visit www.teladoc.com/mobile to download the app. Access Code: VEBA

Kaiser

Kaiser members can get care from a doctor – wherever you are. Do you have a minor health condition? If it doesn't require an in-person medical exam, you may be able to address it with a doctor by E-visit, phone, email or video visit.



E-visit

Fill out a short questionnaire about your symptoms online and get personalized self-care advice from a Kaiser Permanente clinician.



Phone appointment

Schedule an appointment to talk with a Kaiser Permanente clinician over the phone.



Email

Message your doctor's office with non-urgent questions anytime through your kp.org account.



Video Visit

Meet face-to-face with a doctor by video for the same high-quality care as an in-person visit



Mail-order pharmacy

Get prescriptions sent straight to your door with Kaiser's mail-order delivery service.

Some examples of conditions:

- Allergies
- Colds and coughs
- Some follow-up visits
- Upper respiratory infections



Ready to make an appointment?

Go online:

Sign in to kp.org or use the Kaiser Permanente app.

Call 24/7:

1-833-574-2273 (TTY 711)

Dental Benefits

Know Your Options

The dental plan options available to you are worth smiling about. Depending on where you live, Grossmont-Cuyamaca offers you and your family a choice between two dental plans that provide comprehensive coverage and encourage good dental health. You can choose the plan that works best for you.

Employees may choose between the DeltaCare USA Dental Health Maintenance Organization or DHMO plan and the Delta Dental PPO plan. To determine which plan offers the best deal for you, consider the deductibles, annual maximum benefits, coinsurance, copayments and covered expenses.

DeltaCare® USA

DeltaCare DHMO

When you enroll in the DHMO, you must select a Primary Care Dentist (PCD) or Primary Dental Group (PDG) from a defined list of contracted providers. You must access care through your PCD or PDG and seek referrals to specialists from that dentist.

This plan provides basic coverage, at a lower premium cost and offers set copays for covered dental treatments and services, with no cost for your routine preventive care and has no deductible or annual limits on benefits. However, it is important to note that treatment by an out-of-network dentist is not covered.



Delta Dental PPO

The PPO dental plan offers a much larger network of contracted providers. You can visit any licensed dentist under this plan, but you will pay less out-of-pocket when you see an in-network Delta Dental PPO dentist.

In this incentive plan, Delta Dental pays 70% of the PPO contract allowance for covered diagnostic, preventive and basic services and 70% of the PPO contract allowance for major services during the first year of eligibility. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that person visits the dentist at least once during the year. If an enrollee does not use the plan during the calendar year, the percentage remains at the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

When visiting out-of-network providers, patients are responsible for any billed amount that exceeds Delta's reimbursement level. Out-of-network claims are reimbursed based on Delta's PPO reduced fee schedule (RFS).

While PPO plans provide more flexibility and coverage at any dentist, they also include deductibles and annual limits on the benefits paid out. It is always recommended to receive a Pre-Determination of Benefits when services are expected to exceed \$200, this way there are no unexpected charges at the time of service.



Dental Benefits

DeltaCare USA

Understanding your dental insurance coverage is essential for making informed decisions about your oral health care. Regular preventative care is crucial for maintaining good oral health and preventing more serious dental issues. This is a brief summary only and does not fully describe the coverage, exclusions and limitations. For greater detail, please refer to the dental plan's Evidence of Coverage (EOC).

DELTA DENTAL DeltaCare USA HMO Plan CAA16 – Grossmont-Cuyamaca CCD

Disclaimer: These benefits reflect high-level benefit categories for an individual with in-network coverage. Please refer to plan document for details.

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your Benefits Administrator, plan sponsor, or employer).
Deductibles	\$0 per person
Benefits and Covered Services*	DeltaCare USA dentists Member portion / copay
Diagnostic Services — Exams and x-rays	\$0
Preventative Services — 1 cleaning per 6 month period; sealants	\$0
Restorative Services — Fillings, resin-based composites, inlays, onlays, and crowns	\$0
Endodontics (root canals)	\$0
Periodontics (gum treatment)	\$0
Oral and Maxillofacial Surgery	\$0
Prosthodontics (removable) — Bridges, dentures, and implants	\$0 - \$50
Prosthodontics (fixed) — Bridges, dentures, and implants	\$0
Orthodontics	\$1,600 - \$1,800

* Verify your selected DeltaCare USA general dentist before each appointment

Finding a Network Dentist

Members and guests can review provider listings for the DeltaCare DHMO and Delta Dental PPO plans on the Delta Dental website:

1. Visit www.deltadentalins.com

2. Click on  Find a dentist

3. Enter your Search Location

Location*

4. Select one of the following networks:

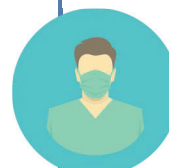
Network*

5. Click on





DeltaCare® USA



Dental Benefits

Delta Dental PPO

Understanding your dental insurance coverage is essential for making informed decisions about your oral health care. Regular preventative care is crucial for maintaining good oral health and preventing more serious dental issues. This is a brief summary only and does not fully describe the coverage, exclusions and limitations. For greater detail, please refer to the dental plan's Evidence of Coverage (EOC).

DELTA DENTAL PPO \$2,000 Plan - Grossmont-Cuyamaca CCD

Disclaimer: These benefits reflect high-level benefit categories for an individual with in-network coverage. Please refer to plan document for details.

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your Benefits Administrator, plan sponsor, or employer).		
Deductibles	None		
Maximums	\$2,000 per person each calendar year		
D & P counts toward maximum?	Yes		
Waiting Periods	Basic Services: None	Major Services: None	Prosthodontics: None
Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**	
Diagnostic & Preventive Services (D & P) Exams, (2) cleanings and x-rays	70 - 100 %	70 - 100 %	
Basic Services Fillings, posterior composites, and sealants	70 - 100 %	70 - 100 %	
Endodontics (root canals) Covered Under Basic Services	70 - 100 %	70 - 100 %	
Periodontics (gum treatment) Covered Under Basic Services	70 - 100 %	70 - 100 %	
Oral Surgery Covered Under Basic Services	70 - 100 %	70 - 100 %	
Major Services Crowns, onlays, and cast restorations	70 - 100 %	70 - 100 %	
Prosthodontics Bridges, dentures, and implants	60 %	50 %	
Dental Accident Benefits	100 % (Separate \$1,000 maximum per person each calendar year)		

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Copays Delta Dental PPO	Member Pays	Dental Insurance Pays
Preventative Service	0 - 30%	70 - 100%
Basic Services	0 - 30%	70 - 100%
Major Services	0 - 30%	70 - 100%

Important Definitions:

- ▶ **Preventative:** routine check-ups, cleanings, and X-rays
- ▶ **Basic:** fillings, extractions, and other minor dental procedures
- ▶ **Major:** more complex procedures such as crowns, bridges, and dentures

Vision Benefits



VSP Vision Plan

The District provides vision benefits through VSP® for benefit-eligible employees and their dependents.

This is a PPO vision plan with a “Non-Referral” based benefit allowing members the most flexibility when choosing their provider. Members receive enhanced benefits with VSP doctors — full-service locations that provide thorough eye exams and a wide selection of quality eyewear. A VSP doctor provides personalized care that focuses on keeping you and your eyes healthy year after year. Plus, when you see a VSP doctor, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Find an eye care provider:

- Find an eye care provider by visiting vsp.com or calling 800.877.7195.
- At your appointment, tell the provider you have VSP. There's no ID card necessary. If you'd like a card as reference, you can print one out at vsp.com.

Create an Account

Create your account on vsp.com:

- View your benefit coverage
- Find the VSP network doctor who's right for you and;
- Discover savings with exclusive member extras.

VSP Vision Care: Provider Network: VSP Signature for Grossmont-Cuyamaca Community College District

Frequency	Every 12 months
WellVision Exam copay	\$10
Routine retinal screening copay	Up to \$39
- Retinal imaging for members with diabetes covered-in-full - Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. - Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	\$20 per exam Frequency: Available as needed
PRESCRIPTION GLASSES	
\$25	
Frames - Every 24 months	
\$170 Featured Frame Brands allowance	Included in Prescription Glasses
\$150 Frame allowance	
\$80 Walmart/Costco frame allowance	
20% savings on the amount over your allowance	
Lenses - Every 12 months	
Single vision, lined bifocal, and lined trifocal lenses	Included in Prescription Glasses
Impact-Resistant for dependent children	
Lens Enhancements - Every 12 months	
Standard progressive lenses	\$0 copay
Premium progressive lenses	\$95 - \$105
Custom progressive lenses	\$150 - \$175
Other lens enhancements	Average savings of 30%
CONTACTS (Instead of Glasses) - Every 12 months	
\$150 allowance for contacts and contact lens exam (fitting and evaluation)	\$0 copay
15% savings on a contact lens exam (fitting and evaluation)	

Important Definitions:

- Routine Eye Exams:** Essential for detecting vision problems and eye diseases early. Insurance typically covers one comprehensive eye exam per year.
- Prescription Glasses:** Vision insurance often provides coverage for prescription glasses, including lenses and frames. Copay and coverage percentage can vary, so it's important to review your plan details to understand your benefits.
- Contact Lenses:** If you prefer contact lenses, this benefit helps reduce the cost of maintaining your preferred vision correction method.
- Additional Services:** Some vision insurance plans offer additional benefits, such as discounts on LASIK surgery or other corrective procedures. Check your plan for details.

Life and Accidental Death & Dismemberment (AD&D)

Basic Life/AD&D

The District provides Basic Term Life and Accidental Death & Dismemberment (AD&D) for all benefit eligible employees through the Hartford. This coverage is part of your district provided benefit package and is designed to safeguard the important people in your life after you're gone. AD&D provides even more coverage if you die or suffer a covered loss in an accident. You must designate your beneficiary online through Workday.

At-a-Glance

- Benefit of \$50,000 to your beneficiaries in the event of your death, plus a matching cash benefit if you die in an accident
- Benefit to you if you suffer a covered loss in an accident, such as losing a limb or your eyesight
- Coverage amounts reduce at age 65 to 65%, age 70 50% and benefits terminate at retirement.

Voluntary Life/AD&D

You may elect to purchase additional coverage for you and your eligible dependents through Hartford's Voluntary Life and AD&D plan. You may choose one of the following options for yourself and up to 50% of that amount for your spouse:

Yourself:

- Minimum of \$10,000, up to 5 times your annual salary, not to exceed \$300,000.

Your Spouse:

- Minimum of \$5,000 to a maximum of \$100,000, not to exceed 50% of the employee's benefit.

Your Child(ren):

- Minimum of \$2,500 to a maximum of \$10,000, not to exceed 50% of the employee's benefit.

Applying for Voluntary Life/AD&D

You must submit an Evidence of Insurability form for any amount of coverage. You will not have voluntary coverage while you are waiting for your application to be approved. Once your coverage is approved, you will pay the appropriate premium.

Continuing Employees

An application is required for any increase in the amount of coverage.

Spouse/Domestic Partner Coverage

You must submit an application for any amount of life insurance that you are electing for your spouse/domestic partner. Your spouse or domestic partner must agree to be covered; therefore, his or her signature is required on the application. Failure to provide spouse/domestic partner signature could result in benefits not being paid in the event of his or her death.

Application Deadlines

To apply for new or increased coverage, you must submit your application as follows:

- During Open Enrollment – Return the completed application to Human Resources before the last day of Open Enrollment
- During the Benefit Year – If you are newly eligible or have a status change, you must return the completed application within 31 days of the date you have a change in family status or within 31 days of completing your eligibility period.

If you do not enroll by these deadlines, your coverage will not be approved and you will be required to wait until the next open enrollment period to reapply.

For applications, enrollment forms, rates and additional coverage information, please contact the Benefits Department by email at Nancy.Hobbs@gcccd.edu or call 619-644-7634.



Employee Assistance

Employees who are enrolled in a District medical plan can access the EAP through OptumHealth - now called Emotional Wellbeing Solutions. When you call, you will be connected with a licensed EAP counselor who will help you determine the most appropriate type of assistance needed.

Support for Personal Problems

- Relationships, grief/loss, family/parenting
- Financial and legal issues
- Anxiety, depression, substance abuse
- Balancing work and family
- Locate childcare and eldercare

Mental Health Support

- Find support groups and community resources
- Online digital cognitive behavioral therapy (dCBT) program
- Modules on topics such as, anxiety, anger management, low self-esteem and more...



Call: 888-625-4809

Web: www.liveandworkwell.com

- **Access Code:** VEBA

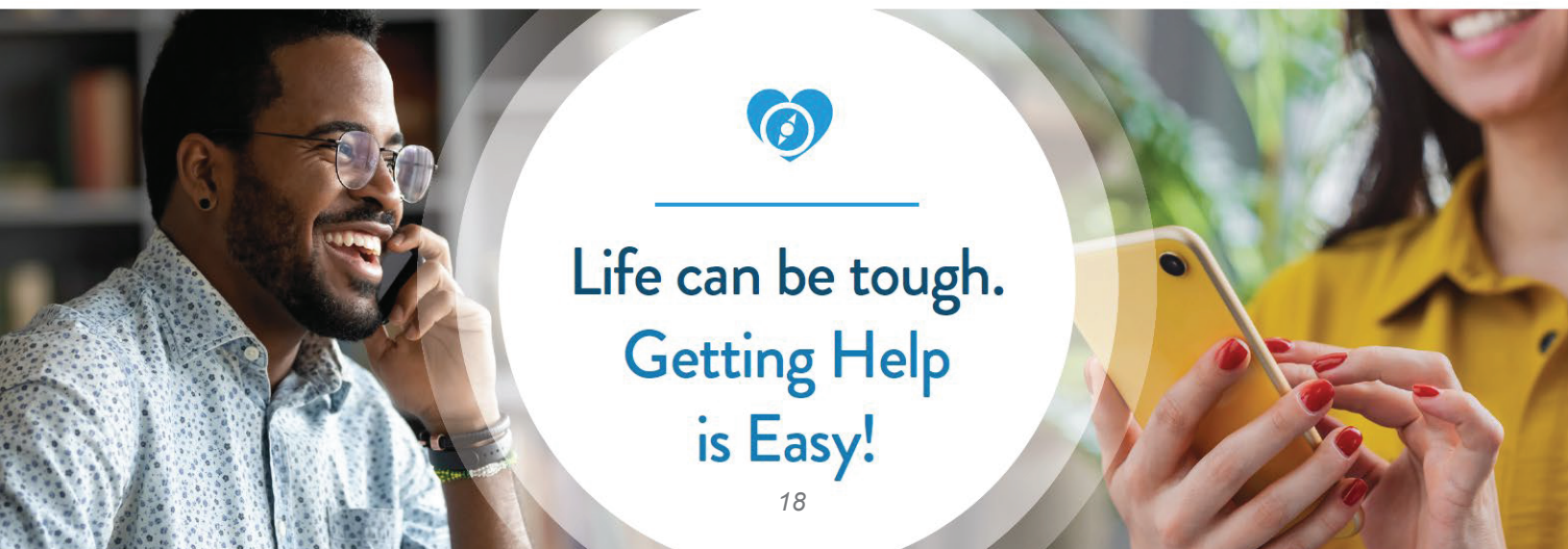
Here's what to expect when you reach out:

When You Need Work/Life Resources

- An EAP Work/Life specialist will gather information about your need for childcare, after-school care, eldercare, special needs, legal or financial resources and more
- Find local resources and check for availability
- Connect you to a legal or financial specialist, if needed

When You Need Counseling Support

- EAP Professional will begin a brief intake process
- Assess for safety concerns
- Gather information about your reason for requesting counseling
- Determine what type of counseling may work best for you (individual, family or couples)
- Connect you to the right professional



Income Protection & Legal Plans

Accident

Accidents happen both on and off the job and can bring unexpected costs. A Limited Benefit Accident Only Insurance policy may lessen the impact on your finances by paying benefits to help cover your expenses, regardless of any other coverage you have.

Cancer

If you're diagnosed with cancer, you may find that your medical insurance doesn't cover everything. In addition to your day-to-day bills, you could incur costs for treatment and recovery, such as:

- Experimental treatment
- Travel, lodging and meals during treatment
- Child care
- Home health services

Cancer insurance helps you focus on the treatment and care you need by paying benefits directly to you to help with your daily out-of-pocket expenses and protect you from financial hardship.



For rates and more information, please contact:

Colonial Life, Account Representative at 714-609-1605 or email: Brian.Akian@coloniallifesales.com

Colonial Life

Critical Illness

Critical Illness Insurance is a supplemental insurance policy that will pay a lump sum if you experience an eligible critical illness, such as heart attack, permanent damage due to a stroke, major organ failure, and/or major burns. Critical Illness Insurance benefits can be used to help pay for your daily living expenses. This plan offers three lump sum benefit amounts to choose from, includes annual health screening test benefit, and benefits that are paid directly to you.

Short-Term Disability

Help maintain your family's lifestyle with income protection in the event of a disabling injury or illness. If you are unable to work due to a covered injury or illness, your monthly benefit payments will allow you to pay your living expenses and make purchases as you need. This plan features several different benefit options, benefit payments deposited directly into your bank account and payable year-round.

Medical Bridge

This program provides a lump-sum cash benefit for hospital confinement and out-patient surgery. Wellness benefits are included.



MetLife Legal Plans

MetLife Legal Plans offer protection at every step with legal coverage to help with life's planned and unplanned events.

During your lifetime, you may need legal help more than you think. Getting married, buying or selling a home, starting a family, identity theft, sending your kids off to college, or caring for aging parents are just some scenarios where experienced attorneys can provide expert legal advice.

Employees may enroll in coverage for themselves or the MetLife Legal Plans Plus Parents to include coverage for your parents, grandparents, and in-laws.

To Enroll:

Complete your enrollment in Workday. You will also need to complete the MetLife Legal enrollment form and return to the Benefits team.

Flexible Spending Accounts (FSA)

Understanding Your Section 125 Flexible Spending Account Options

Under Section 125 of the IRS code, you are allowed to deduct needed benefits from gross earnings before taxes are computed. The advantage of this Plan is simple: The eligible premiums you pay are deducted on a pre-tax basis. In addition, Section 125 also allows you to set aside additional income in Flexible Spending Accounts to reimburse out-of-pocket health and dependent care expenses that you, your spouse, and eligible child(ren) incur during the year.

When you participate in the FSAs, you can direct a part of your pay, on a pre-tax basis, into a special account that can be used to reimburse yourself tax-free as you incur expenses. You decide whether to participate in one or both of the accounts each year. As you incur eligible expenses throughout the year, you reimburse yourself for those expenses out of the appropriate account with your tax-free dollars.

This plan offers two (2) ways to help you pay for certain, necessary expenses with tax-free dollars:

1. Health Care Flexible Spending Account (HCFSA)
2. Dependent Care Account (DCA)

You may enroll in just one or both plans – it's your choice!

Health Care Flexible Spending Account

- Set aside up to \$3,400 pre-tax in 2027 to reimburse eligible medical expenses including copays, deductibles, prescriptions, and many other health care expenses that may not be covered by insurance.
- Participants have a 2.5 month grace period following the end of the plan year to incur claims and receive reimbursements. For example, the plan year ends on December 31, but employees will have an additional 2.5 months after the plan year ends to incur and submit claims for reimbursement.
- Keep in mind the "Use-it-or-lose-it" rule. Any unused balance after the end of the 2.5 month grace period will be lost, so please carefully estimate.

Dependent Care Account

- Set aside up to \$7,500 pre-tax each year to reimburse eligible daycare services (\$3,750 if married and filing separate tax returns).
- The IRS tax code defines a qualified dependent as a child who has not reached the age of 13, a relative or spouse who is physically or mentally incapable of self-care and has the same principal residence as the taxpayer for more than half of the year.



To enroll, complete your election during your initial enrollment or annual open enrollment period. While you can make changes to your election each year during open enrollment, the only time regulations will allow you to make a change mid-year is if you experience a qualifying life event. All elections must be made through Workday.

How to Check Your Balance or Claim Status:

Participants have several options to inquire on the status of your reimbursement account.

1. By Internet: www.tasconline.com
2. Call Customer Service: At 1-800-422-4661 from 8:00am to 5:00pm (CST), Monday through Friday.

Direct Deposit: FSA participants can have your account set up for direct deposit. You can either have your reimbursement directly deposited into your checking account or receive a check in the mail – the choice is up to you.

FSA Debit Card: If you enroll in the Health Care Reimbursement Account, you can choose to use an FSA Debit Card. The card gives you immediate access to your funds at the point of sale, making it easier to pay for prescriptions, copays and other common medical expenses without having to file a claim.

Work Benefits



The District is pleased to continue our partnership with TicketsatWork where employees have access to exclusive savings on movie tickets, theme parks, hotels, tours, Broadway and Vegas shows and more.

Be sure to visit often as new products and discounts are constantly being added!



For Customer Service:

Call: 1-800-331-6483

Email: customerservice@ticketsatwork.com

Company Code: GCCCD

**MEMBERS
HAVE MORE
FUN!**

Sign Up Today in 60 Seconds!

1. Visit www.ticketsatwork.com
2. Click on the "Become a Member" box at the top of the homepage.
3. You will then be prompted to create an account with your email address and company code: **GCCCD**
4. Or, you can place your order by phone. Call customer service at 800-331-6483. Orders are taken from 8:30am-12am/7 days a week (holidays included). Eastern Standard Time.



FBC Model Plan Program Highlights

Brought to you by



**Fringe Benefits
Consortium**



Powered by PlanMember®

The FBC Model Plan is a comprehensive program offering financial wellness, education, and personalized retirement planning services to FBC members. It was originally offered to the educational community in San Diego County to help them grow their savings and achieve their retirement dreams in a manner that was typically only available to the private sector. Today, the FBC Model Plan spans three counties and is available in more than a hundred community college districts, school districts, and charter schools. As a member of the FBC, your employer has elected to provide the FBC Model Plan as a benefit to help you save for retirement and beyond.

Below are highlights of the FBC Model Plan. For more detailed information, or to enroll, visit FBCmodelplan.com on your computer, smart phone, or tablet, or call, (833) 752-6322 (Plan-FBC).

If there are any discrepancies between this document and the Plan Document, the Plan Document will govern.

Join the FBC Model Plan

All full and part-time employees are eligible to participate in the plan. New employees can enroll immediately on their date of hire or anytime afterwards.

Contributions

Contributions or changes to contribution amounts are subject to payroll processing deadlines. Contact SchoolsFirst directly or log into your Plan Vue account to make changes.

Pre-tax 403(b) and 457(b) contributions

These plans allow you to save part of your income on a pre-tax basis. This lowers your current taxable income. The money grows tax free and can help your long-term savings grow faster. Money invested will not be taxed until withdrawn.

After-tax Roth 403(b) contributions

Roth contributions enable you to save on an after-tax basis meaning you pay taxes before making your contributions. Upon retirement, qualified distributions are tax free.

Catch-up contributions

If you are age 50 or older and make the maximum allowable deferral to your account, you are entitled to contribute additional “catch-up contributions.” This is intended to help eligible employees make up for savings short-falls as they approach retirement.

Why you should invest for your future

Saving in your employer’s plan is the best way to prepare for retirement. It’s easy, convenient, flexible, and is designed to meet your needs wherever you are on your financial journey. CalSTRS and CalPERS are designed to provide a base income and not replace your entire income. Through the FBC Model Plan you can save additional dollars and maximize the power of long-term compound growth. The sooner you start to save, the sooner your money can start working for you, and it is never too late to start!

Continues ►

Call: (833) 752-6322 (Plan-FBC)

Email: FBCsupport@planmember.com | fbcmodelplan.com

Who should enroll

This program is for you whether you are part-time, full-time, classified, certified, just starting out, thinking of retirement, or anywhere in between.

Plan contributions

First, you'll need to choose a plan. Visit fbcmodeplan.com/enroll to learn more about your options. After enrollment, you will determine how much to save and complete the appropriate paperwork. SchoolsFirst Plan Administration LLC is the third-party administrator (TPA) contracted to provide regulatory guidance over the plan. As such, they receive all salary reduction agreements (SRAs) and work with your payroll department to oversee all transactions for IRS compliance.

Withdrawals

You can withdraw money penalty free at age 59½. Both the 403(b) and 457 plans allow for loans and distributions due to hardship and unforeseen emergencies. Penalties may apply and withdrawals may be subject to taxes for other reasons. Be sure to talk with your tax advisor before withdrawing any money from your account.

Hardship or an unforeseen emergency

If you have an immediate financial need as a result of severe hardship and you lack other reasonably available resources to meet that need, you may be eligible to

make a hardship withdrawal from your account. You may also be eligible to withdraw funds if you have met an unforeseeable emergency as defined in the Plan Document.

Plan loans

While the plan is intended to help you build retirement savings, it is not uncommon that financial emergencies arise, so plan loans are available. The loan amount is limited by rules under the tax law.

Investments

The FBC Model Plan offers you full-service and self-service options. You can choose the level of support and involvement that best serves your needs. Investment options will vary depending on the plan you choose.

Fees

Program fees will vary depending on the type of investment you choose. These are generally collected from your investment account so you will never receive a bill. Charges for services will be detailed when setting up your account.

Help is available

A dedicated FBC Model Plan phone number and email have been established to serve you. You can connect with an FBC dedicated representative who is fully licensed and will not be servicing other plans.

Call: (833) 752-6322 (Plan-FBC)

Email: fbcsupport@planmember.com | Website: fbcmodeplan.com

Additional details on these topics are available at fbcmodeplan.com.

In addition, we encourage you to use the assortment of financial calculators, articles, and videos available.

Investors should carefully consider the investment objectives, risks, charges, and expenses of a mutual fund before investing. This and other important information is contained in the prospectuses or summary prospectuses, which can be obtained from the financial professional for your plan and should be read carefully before investing. All investments may involve risk, including possible loss of principal. Asset allocation or the use of an advisor does not ensure a profit or guarantee against loss.

Representatives registered with and offer only securities and advisory services through PlanMember Securities Corporation, a registered broker/dealer, investment advisor, and member FINRA / SIPC. PlanMember Securities Corporation and Fringe Benefits Consortium are independently owned and operated.
6187 Carpinteria Ave., Carpinteria, CA, 93013 • (800) 874-6910

Contact Information

Carrier	Phone	Online	Policy #/ Reference
Kaiser HMO	800-464-4000	www.kp.org	Medical record # on Kaiser ID card
UnitedHealthcare (UHC) HMO Member Services Express Scripts EnGuide Pharmacy/EnReach Rx	888-586-6365 800-918-8011 800-282-2881	www.myuhc.com www.expressscripts.com www.enguidepharmacy.com	UHC ID card ES ID card
VEBA Direct HMO	800-642-8822	https://www.vebaonline.com/veba-direct/	Plan ID Card
VEBA Programs Advocacy & Wellness Teladoc Medical Experts	888-276-0250 800-835-2362	https://www.vebaonline.com/contact/ www.teladochealth.com/medical-experts	GCCCD VEBA
Optum Health Chiropractic & Acupuncture	800-428-6337	www.myoptumhealthphysicalhealthofca.com	VEBA
SIMNSA Health Plan Cross-Border HMO Plan	San Diego: 619-407-4082 Tijuana: 664-231-4747	www.simnsa.com	
Optum Emotional Wellbeing Solutions (EWS) 24-7 Referrals and EAP	888-625-4809	www.liveandworkwell.com	access code: VEBA
Delta Dental DHMO Member Services PPO Member Services	800-422-4234 866-499-3001	www.deltadentalins.com	
VSP Vision Plan	800-877-7195	www.vsp.com	121832780
McGriff COBRA	888-888-3442	https://cobralogin.mcgriffinsurance.com	
The Hartford Basic & Supplemental Life Supplemental AD&D Long Term Disability	888-563-1124 888-563-1124 888-277-4767	www.thehartford.com	875040 S07819 Plan A 875040
TASC FSA	800-422-4661	www.tasconline.com	GCCCD
Unum Long Term Care Enrollment & Benefit Questions	Claims: 800-693-4988 800-227-4165	www.unuminfo.com/consortium	105237 -023
Met Life Pre-Paid Legal Services	800-821-6400	https://info.legalplans.com	access code: 1680005
Colonial Life Income Protection Plans Enrollment/Changes Member Services	Brian Akian 714-609-1605 800-325-4368	Brian.Akian@ColonialLifeSales.com www.coloniallife.com	E4471892
FBC Deferred Compensation Plan SchoolsFirst Customer Service Retirement Plan Advisor	800-462-8328 ext. 4727 833-752-6322	https://tinyurl.com/FBCDeferredComp https://pa.schoolsfirstfcu.org/ FBCSupport@planmember.com	GCCCD
Human Resources Benefits Technician	619-644-7643	www.gcccd.edu/benefits/default.html	

Glossary of Medical Terms

This glossary has many commonly used terms but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document).

Coinsurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay the coinsurance *plus* any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is \$100 and you've met your deductible, your Coinsurance payment of 20% would be \$20.

Copayment: A fixed amount (for example, \$20) you pay for a covered health care service, usually when you receive the service.

Deductible: The amount you owe for health care services your health insurance or plan covers before it begins to pay. For example, if your deductible is \$1,000, your plan won't pay anything until you've met your \$1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

In-network Coinsurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network Coinsurance usually costs you less than out-of-network coinsurance.

In-network Copayment: A fixed amount (for example, \$20) you pay for covered health care services to providers who contract with your health insurance or plan. In-network Copayments usually are less than out-of-network copayments.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Out-of-network Coinsurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment: A fixed amount (for example, \$30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-Pocket Maximum: The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount.

Prescription Drug Formulary: A list of prescription drugs, both generic and brand name, used by practitioners to identify drugs that offer the greatest overall value. A committee of physicians, nurse practitioners, and pharmacists maintain the formulary. Some health insurance or plans do not cover non-formulary drugs or they are covered at a higher out-of-pocket cost.

Preventive Care: Recommended care you receive, based on age and gender, to prevent illnesses or diseases. It also includes counseling to prevent health problems. These services are usually provided at no cost if you use your primary care provider or preferred provider. Once you have received a diagnosis, services are no longer considered preventive.

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Required Notices

The following is a brief description of the Annual Disclosure Notices that various state and federal laws require employers to provide annually to eligible plan participants. Please log in to the District's benefits enrollment portal to access the full disclosures. If you are unable to access these for any reason, please contact Human Resources for a printed copy.

Medicare Part D Creditable Coverage Notice states that Medicare prescription drug coverage became available in 2006 and that the prescription drug coverage offered by your employer is on average expected to pay out as much as standard Medicare coverage pays and is therefore considered Creditable Coverage.

Women's Health and Cancer Rights Act (WHCRA) of 1998 protects 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.

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

HIPAA Notice of Special Enrollment Rights provides information on special enrollment periods (outside of Open Enrollment) for loss of prior coverage or addition of a new dependent.

HIPAA – Notice of Privacy Practices

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.

Notice of Choice of Providers states that you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, the medical carrier designates one for you.

Children's Health Insurance Program (CHIP) Notice provides information on how to contact your state Medicaid office (where applicable) to receive information on assistance if you are eligible for health coverage from your employer but are unable to afford the premiums.

ACA Disclaimer

This notice is intended to inform employees that this offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.96% in 2026 of your modified adjusted household income and 10.22% in 2027.

The "No Surprises" Rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers..

General Notice of COBRA Continuation explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.



GROSSMONT-CUYAMACA
COMMUNITY COLLEGE DISTRICT

The information in this Benefits Summary is presented for illustrative purposes. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. If you have any questions about this summary, contact the Employee Benefits Department.