BENEFITS GUIDE

CSEA, Local 707
Administrators Association

Eligibility • Enrollment • Medical • Dental
Vision • Life • Disability • EAP Program
Voluntary Benefits

GROSSMONT-CUYAMACA
COMMUNITY COLLEGE DISTRICT

CONTENTS

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by Grossmont-Cuyamaca Community College District. 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 of 1996. If you have any questions about this summary, contact Human Resources.

BENEFITS ELIGIBILITY

REGULAR FULL-TIME EMPLOYEES

► **50%+ FTE CSEA**
► **50%+ FTE Administrators Association**

- California Schools VEBA Medical (Kaiser, United Healthcare (UHC), UMR & SIMNSA)
  - » Prescription Drug Plan
  - » Chiropractic & Acupuncture (not included with SIMNSA Medical)
  - » Employee Assistance Plan (EAP)
  - » Advocacy & Wellness
- DeltaCare DHMO & Delta Dental PPO
- VSP Vision PPO
- Hartford Life Insurance and Accidental Death & Dismemberment (AD&D)
- Hartford Long Term Disability (LTD)
- Unum Long Term Care (LTC)
- MetLife Legal Services
- TASC Flexible Spending Accounts (FSA)
- Colonial Life Voluntary Plans
- Deferred Compensation Plans
- Liberty Mutual Auto & Home Insurance
- Liberty Mutual Pet Discount Program (Hartville)

OTHER EMPLOYEES

► **<50% FTE CSEA**
► **<50% FTE Administrators Association**

- Colonial Life Voluntary Plans
- Deferred Compensation Plans
- Liberty Mutual Auto & Home Insurance
- Liberty Mutual Pet Discount Program (Hartville)

YOUR ENROLLMENT RIGHTS

WHEN TO ENROLL

You can enroll in coverage within 31 days of your eligibility date or during the annual Open Enrollment period which occurs during October and November each year.

The coverages you elect during open enrollment or initial eligibility cannot be changed during the plan year unless you have a qualifying life event as recognized under IRS regulations *(see Making Changes During the Year for details)*.

MAKING CHANGES DURING THE YEAR

The choices you make when you first become eligible remain in effect for the remainder of the year. Once you are enrolled, you must wait until the next open enrollment period to change your benefits or add or remove coverage for dependents, unless you have a qualified change in family status as defined by the IRS.

Examples include:

- Marriage, divorce, legal separation, or legal annulment
- Birth or adoption of a child
- Loss of other health coverage
- Death of a dependent
- Employment status change including termination or commencement of employment by the employee, spouse or dependent
- Reduction or increase in work hours which causes a loss or gain in eligibility
- Change in your dependent's eligibility status because of marriage, age, etc.

You are responsible for notifying Human Resources within 31 days of any qualifying life event that would cause a change in benefit status, including a COBRA eligibility change. **Note:** Any change you make to your coverage must be consistent with the change in status.

PROOF OF DEPENDENT ELIGIBILITY

If you are enrolling any dependents, you must submit proof of dependent eligibility (e.g., a certified and/or notarized copy of a marriage certificate, Declaration of Domestic Partnership form, or birth or adoption/court-appointed guardianship certificate). If you do not remove an ineligible dependent, you may be charged and their healthcare services will not be covered.

WAIVING MEDICAL COVERAGE

Employees can opt-out* of enrolling in a medical plan. Proof of other medical enrollment must be provided to qualify for this waiver. Contact the Benefits Technician for next steps.

** Opt-outs are available during open enrollment or within 31 days of enrollment in a qualified external medical plan.*

You are eligible for the District's benefits on the first of the month following your date of hire.

You may enroll your eligible dependents in the same plans you choose for yourself. Eligible dependents include your legal spouse or registered domestic partner and your children up to age 26.

If you are enrolling during the open enrollment period, any benefit changes you make will be effective January 1.

MEDICAL PLAN HIGHLIGHTS

Nothing is more important than you and your family's health and is why the District offers you medical plan choices designed to help you get the care you need at a price you can afford. Your options include eight HMO plans and a PPO plan.

If you enroll in an HMO, you must select a primary care physician (PCP) from the plan's network of providers. Your PCP directs your health care and will refer you to specialists or other providers within their network. Only in-network care is covered under an HMO, except in the case of a true emergency as determined by the plan.

If you enroll in the PPO, you have the freedom to visit any licensed provider each time you need care; however, you will save money when you visit preferred providers.

UNITEDHEALTHCARE HARMONY HMO PLAN

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. You and your dependents may choose different PCPs as long as they are all within the Harmony plan.

UNITEDHEALTHCARE PERFORMANCE HMO PLANS

This plan helps you make informed decisions about the PCP you choose. Copays vary by network: PCPs in Network 1 have the highest performance ratings and the lowest copays. You and your dependents must choose the same network—but your PCPs can be different. Although you can change PCPs within your network at any time, you cannot change between Networks 1, 2 or 3 during the year. You may switch to a different network only during open enrollment.

San Diego County Provider Medical Groups

NEW! Harmony Network
Primary Care Associated Medical Group
SCMG Arch Health Partners (Sharp)
Sharp Community Medical Group
Sharp Rees-Stealy Medical Group Inc.
UCSD Medical Group

Network 1
Primary Care Associated Medical Group
Rady Children's Health Network
SCMG Arch Health Partners (Sharp)
Sharp Community Medical Group
Sharp Rees-Stealy Medical Group Inc.

Network 2
Greater Tri-Cities IPA Medical Group
Mercy Physicians Medical Group
Rady Children's Health Network
SCMG Arch Health Partners (Sharp)
Scripps Physicians Medical Group

NEW! Network 3
Rady Children's Health Network
Scripps Clinic
Scripps Coastal Medical Center

MEDICAL PLAN HIGHLIGHTS

UNITEDHEALTHCARE SIGNATURE VALUE ALLIANCE HMO PLANS

The Signature Value Alliance HMO Plans allow 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. You and your family must all enroll in the same Alliance Plan for the entire year and choose a PCP from the Alliance Network medical groups, however, you can all select different PCPs and/or medical groups and change at any time during the year. Your PCP will be your first source for care and will coordinate any care needed.

San Diego County Provider Medical Groups

Alliance Network

Mercy Physicians Medical Group
Primary Care Associated Medical Group
Rady Children's Health Network
Scripps Clinic
Scripps Coastal Medical Center
Scripps Physicians Medical Group
UCSD Medical Group

Health Reimbursement Account (HRA)

The Alliance HRA 1200 plan comes with a $1,200 HRA to use for your qualified out-of-pocket medical expenses. The HRA plan combines a high-deductible health plan with a VEBA funded account that helps you meet your deductible. When you enroll in the Alliance HRA 1200 plan, you will receive two debit cards loaded with a total of $1,200 for immediate use to pay for your qualified, out-of-pocket medical expenses including copays, coinsurance, pharmacy, and chiropractic. Also, up to $500 of unused HRA balance can be rolled over for the following year.

The HRA is not available for the Alliance 20/30 plan.

KAISER PERMANENTE HMO PLAN

Kaiser'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 one-stop shopping because most facilities feature medical offices, labs and pharmacies all 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.

My Health Manager is your personal health record at www.kp.org and you and your covered family members are encouraged to use it and have access to:

My message center: Email your doctor's office with questions securely and conveniently.

My coverage and costs: Learn about your benefits, download forms, pay bills and more.

Appointment center: Schedule, view or cancel upcoming appointments and view past visits.

Pharmacy center: Manage your prescriptions or learn about specific medications in the drug encyclopedia.

My medical record: View test results, immunizations and health reminders. Also, manage your family's health plan.

MEDICAL PLAN HIGHLIGHTS

SIMNSA CROSS-BORDER HMO PLAN

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 the network extends through the border cities of Tijuana, Tecate and Mexicali with the following features:

- Affordable and culturally sensitive health care
- Licensed by the California Department of Managed Health Care
- Routine services must be received in Mexico
- Worldwide emergency and urgent care services
- No copays for preventive care services
- Clinics are open 7 days a week
- No appointments necessary
- No PCP election required
- Includes other VEBA benefits (Best Doctors, EAP, Wellness Programs)

UMR NEXUS ACO PPO

The Nexus Accountable Care Organization (ACO) Preferred Provider Organization (PPO) medical plan requires that each family member designates a Primary Care Physician, however members have the freedom to chose any recognized provider or hospital when accessing care.

Keep in mind, the amounts facilities charge for standard services can vary greatly based on where that service is delivered and there are significant cost advantages when utilizing the Nexus ACO providers (Tier 1) and Select Plus PPO providers (Tier 2).

Tier 1 – Nexus ACO Providers are high quality providers in Sharp Rees-Stealy and Sharp Community medical groups. Office visits in this network are not subject to the deductible.

Tier 2 - Select Plus Network offers broad access to discounted health care services and no balance billing.

Out-of-Network Providers set their own prices and you may be responsible for and balance billed for amounts higher than the Select Plus PPO negotiated rate.

Carrum Health is a surgery benefit delivering cost savings and access to the highest quality surgeons who have proven to have the best outcomes for the covered procedures. This benefit is available for Spine Procedures, Hip and Knee Replacement, and Coronary Artery Bypass Graft (CABG). Members who do not contact Carrum Health prior to scheduling one of these types of procedures will be required to pay a $1,000 pre-certification penalty in addition to your plan deductibles and coinsurance.

MEDICAL PLAN OPTIONS

Medical Plan Name	UnitedHealthcare Harmony HMO Plan 10	UnitedHealthcare Performance HMO Plan A		UnitedHealthcare Performance HMO Plan 20
Network Name	**Harmony**	**Network 1**	**Network 2**	**Network 3**
Calendar Year Deductible	None	None	None	None
Out-of-Pocket Maximum	$1,500 individual $3,000 family	$1,500 individual $3,000 family	$3,000 individual $6,000 family	$1,500 individual $3,000 family
Preventive Care Services	No charge	No charge	No charge	No charge
PCP Office Visit	$10 copay	$10 copay	$20 copay	$20 copay
Specialist Office Visit	$10 copay	$10 copay	$20 copay	$20 copay
Inpatient Hospital	No charge	No charge	No charge	$250 copay per admit
Outpatient Surgery (ambulatory surgery center or physician's office)	No charge	No charge	No charge	No charge
Outpatient Surgery (outpatient hospital-based surgical center)	No charge	No charge	No charge	No charge
Mental Health Services (outpatient/inpatient)	$10 copay/ No charge	$10 copay/ No charge	$20 copay/ No charge	$20 copay/ $250 copay per admit
Substance Abuse (outpatient/inpatient)	No charge	No charge	No charge	No charge
Diagnostic Lab/Radiology (standard)	No charge	No charge	No charge	No charge
Complex Radiology (PET & MRI)	No charge	No charge	No charge	$100 copay
Outpatient Physical & Rehab Therapy (PCP/Specialist)	$10/$10 copay	$10/$10 copay	$20/$20 copay	$20/$20 copay
Urgent Care Visits (PCP medical group/ other medical group)	$10/$50 copay	$10/$50 copay	$20/$50 copay	$20/$75 copay
Emergency Room (copay waived if admitted)	$100 copay	$100 copay	$100 copay	$150 copay
Chiropractic and Acupuncture Services (through OptumHealth)	$10 copay	$10 copay	$20 copay	$20 copay

MEDICAL PLAN OPTIONS

Medical Plan Name	UnitedHealthcare Alliance HMO Plan 20/30	UnitedHealthcare Alliance HMO Plan HRA 1200	Kaiser Permanente HMO Plan 10	SIMNSA Cross-Border HMO
Network Name	**Alliance**	**Alliance**	**Kaiser**	**SIMNSA**
Calendar Year Deductible	None	$2,000 individual $2,000 family	None	None
Out-of-Pocket Maximum	$3,000 individual $6,000 family	$3,000 individual $6,000 family	$1,500 individual $3,000 family	$6,350 individual $12,700 family
Preventive Care Services	No charge	No charge	No charge	No charge
PCP Office Visit	$20 copay	$35 copay	$10 copay	$5 copay
Specialist Office Visit	$30 copay	$50 copay	$10 copay	$5 copay
Inpatient Hospital	$500 copay	20% after deductible	No charge	No charge
Outpatient Surgery (ambulatory surgery center or physician's office)	$250 copay	20% after deductible	$10 copay	No charge
Outpatient Surgery (outpatient hospital-based surgical center)	$250 copay	20% after deductible	$10 copay	No charge
Mental Health Services (outpatient/inpatient)	$20 copay/ $500 copay	$40 copay/ 20% after deductible	$10 copay/ No charge	$5 copay/ No charge
Substance Abuse (outpatient/inpatient)	No charge	No charge	$10 copay/ No charge	$5 copay/ No charge
Diagnostic Lab/Radiology (standard)	No charge	No charge/ 20% after deductible	No charge	No charge
Complex Radiology (PET & MRI)	$200 copay	20% after deductible	No charge	No charge
Outpatient Physical & Rehab Therapy (PCP/Specialist)	$20 copay	$35 copay	$10/$10 copay	$10/$10 copay
Urgent Care Visits (PCP medical group/other medical group)	$20 copay/ $75 copay	$35 copay/ 20% after deductible	$10 copay (any Kaiser facility)	$25 copay/ $50 copay
Emergency Room (copay waived if admitted)	$150 copay	$300 copay after deductible	$50 copay	$250 copay
Chiropractic and Acupuncture Services (through OptumHealth)	$20 copay	$30 copay	$10 copay	Not covered

MEDICAL PLAN OPTIONS

UMR

Medical Plan Name	UMR PRO		
Network Name	**Tier 1 - Nexus ACO**	**Tier 2 - Select Plus**	**Out-of-Network**
Calendar Year Deductible	$2,000/person | $4,000/family (combined between all network levels)		
Out-of-Pocket Maximum	$5,000/person | $10,000/family (combined between all network levels)		
Preventive Care Services	No charge	No charge	Not covered
PCP Office Visit	$30 copay	20% after deductible	50% after deductible
Specialist Office Visit	$50 copay	20% after deductible	50% after deductible
Inpatient Hospital	20% after deductible	20% after deductible	50% after deductible with prior authorization
Outpatient Surgery (ambulatory surgery center or physician's office)	20% after deductible	20% after deductible	50% after deductible with prior authorization
Outpatient Surgery (outpatient hospital-based surgical center)	$100 copay + 20% after deductible	$100 copay + 20% after deductible	50% after deductible with prior authorization
Mental Health Services (outpatient/inpatient)	$30 copay/ 20% after deductible	$30 copay/ 20% after deductible	50% after deductible
Substance Abuse (outpatient/inpatient)	$30 copay/ 20% after deductible	$30 copay/ 20% after deductible	50% after deductible
Diagnostic Lab & Radiology (standard)	No charge	20% after deductible	50% after deductible
Complex Radiology (PET & MRI)	20% after deductible	20% after deductible	50% after deductible
Outpatient Physical & Rehab Therapy (PCP/Specialist)	$30 copay	$30 copay/ 20% after deductible	50% after deductible
Urgent Care Visits (PCP medical group/other medical group) Outpatient Physical & Rehab Therapy (PCP/Specialist)	$50 copay	$50 copay	50% after deductible
Emergency Room (copay waived if admitted)	$100 copay	$100 copay	$100 copay
Chiropractic and Acupuncture Services (through OptumHealth)	$30 (Optum network)	$30 (Optum network)	50% after deductible

PRESCRIPTION DRUG PLANS

If you are enrolled in one of the UHC HMO plans or the UMR Nexus ACO PPO plan, your prescription drug benefits are through Express Scripts (ESI). Within the ESI network, some pharmacies have negotiated special pricing establishing smaller, more cost effective options. Your prescription drug plan will reward you with lower copays when using these more cost-effective pharmacies.

ESI Advantage Network (EAN)

- **Supermarkets**
- **Drug Stores**
- **Many Independents**

Provides access to more than 200 locations in San Diego where you will pay standard copays for up to a 30-day supply of short-term drugs

Smart90 Network

- **Rite Aid**
- **Costco**
- **Express Scripts Mail Order Pharmacy**

Pay 1 copay for up to a 30-day supply of short-term drugs or receive up to a 90-day supply of maintenance drugs for 2 copays. Copays waived for preferred generic hypertension drugs and oral hypoglycemic at Smart90 or mail order!

All Other ESI Network Pharmacies

- **Walgreens**
- **CVS**
- **Some Independents**

Choosing to fill your prescription here will result in paying the standard copay plus an additional $5 per prescription

SaveOnSP – The SaveOnSP program through Express Scripts is designed to reduce or eliminate out-of-pocket costs on select specialty medications. Enrollment in the program is voluntary; however, if you choose not to participate, you will be responsible for the full copay on certain medications which will lead to additional costs. The copay will not count towards your deductible or out-of-pocket maximum. The specialty drug list is subject to change and members will be notified if their specialty medication applies to this program. For further information, please contact SaveOnSP at 800-683-1074.

Step Therapy simply means making sure you get safe and proven-effective medications at the lowest possible cost to you and your plan sponsor. A panel of independent licensed medical experts work with Express Scripts to recommend medications for the step therapy program. If taking a medication on the step therapy program, you are required to try a first-line medicine before a second-line medicine is covered.

- First-line medications are the first step and are typically generic and lower-cost brand-name medications. In most cases, they provide the same health benefit as more expensive medications, but at a lower cost.
- Second-line medications are the second and third steps and are typically brand-name medications. They are best suited for the few patients who don't respond to first-line medications. They're also the most expensive options.

Inside Rx Pets is a pet prescription discount program administered by Inside Rx, LLC, a partially owned subsidiary of Express Scripts. This program expands affordable access to brand and generic human medications for pets. This is a value-added perk at no cost to members who are enrolled in one of the VEBA medical plans.

Just go to the website at https://insiderxpets.com to download and print your card. Show your prescription and card to gain access to the lowest possible pricing on your pets medications at nearly 40,000 participating retail pharmacies.

PRESCRIPTION DRUG PLANS

COPAYS FOR UHC & UMR MEDICAL PLANS:

EXPRESS SCRIPTS®

	EAN			Smart90 and Home Delivery			Other ESI		
	Generic*	Preferred Brand	Non-Preferred Brand**	Generic*	Preferred Brand	Non-Preferred Brand**	Generic*	Preferred Brand	Non-Preferred Brand**
UHC Harmony, UHC Network 1									
Short-Term Drugs (up to 30-day supply)	$5	$25	50%	$5	$25	50%	$10	$30	50%
Maintenance Drugs (up to 90-day supply)***	$10	$50	50%	$10	$50	50%	*Not available*		
Out-of-Packet Maximum (individual/family)	$3,000/$6,000 (shared between all pharmacy benefit levels)			$3,000/$6,000 (shared between all pharmacy benefit levels)			$3,000/$6,000 (shared between all pharmacy benefit levels)		
UHC Network 2									
Short-Term Drugs (up to 30-day supply)	$10	$30	50%	$10	$30	50%	$15	$35	50%
Maintenance Drugs (up to 90-day supply)***	$20	$60	50%	$20	$60	50%	*Not available*		
Out-of-Packet Maximum (individual/family)	$3,000/$6,000 (shared between all pharmacy benefit levels)			$3,000/$6,000 (shared between all pharmacy benefit levels)			$3,000/$6,000 (shared between all pharmacy benefit levels)		
UHC Network 3, UHC Alliance 20/30, UHC Alliance HRA 1200, UMR PPO									
Short-Term Drugs (up to 30-day supply)	$10	$30	50%	$10	$30	50%	$15	$35	50%
Maintenance Drugs (up to 90-day supply)***	$20	$60	50%	$20	$60	50%	*Not available*		
Rx Out-of-Packet Maximum (individual/family)	$1,600/$3,200 (shared between all pharmacy benefit levels)			$1,600/$3,200 (shared between all pharmacy benefit levels)			$1,600/$3,200 (shared between all pharmacy benefit levels)		

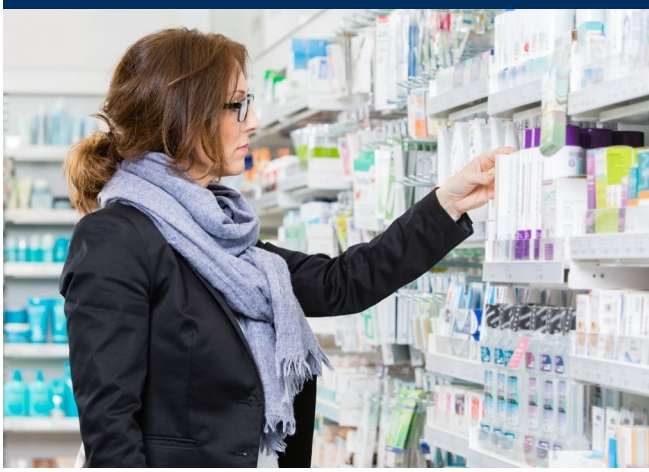
**Zero copays for generic hypertension drugs and oral hypoglycemis at Smart90 or mail order.*
***Short-term drugs are subject to $40 minimum and $175 maximum and maintenance are subject to $80 minimum and $350 maximum.*
****The 4th and following fills of maintenance drugs must be through a Smart90 pharmacy or Express Scripts Home Delivery to avoid a penalty of 2 times the short-term drug copay.*

COPAYS FOR KAISER & SIMNSA MEDICAL PLANS:

Kaiser HMO KAISER PERMANENTE®	
Prescription Drugs - Retail (up to 30-day supply at Kaiser Pharmacy) Generic/Preferred Brand Name Drugs	$10/$10 copay
Prescription Drugs - Mail Order (up to 100-day supply through Kaiser's mail order service) Generic/Preferred Brand Name Drugs	$10/$10 copay
Out-of-Packet Maximum (individual/family)	Included in medical
SIMNSA Cross-Border HMO SIMNSA	
Prescription Drugs - Retail Generic/Brand Name Drugs	$5/$5 copay
Prescription Drugs - Mail Order	Not Available
Out-of-Packet Maximum (individual/family)	Included in medical

IMPORTANT

If you choose a brand-name drug when a generic is available, you will pay the generic copay plus the difference in cost between the generic and brand-name even if your doctor rights "dispense as written"



ADVOCACY & EMPLOYEE ASSISTANCE PROGRAM

VEBA ADVOCACY SERVICES
Call 888-276-0250

Monday – Friday, 8am-5pm
except major holidays
Email info@vebaonline.com

Contact Your VEBA Advocate if you:

- Have questions about your patient rights
- Are facing a serious medical issue and don't know what to do
- Need help or more information to resolve a medical quality or access problem that you can't resolve through your provider or health care plan

TELEDOC MEDICAL EXPERTS
The Teledoc Medical Experts program provides free consultation with medical experts if you have a question about your health or are diagnosed with a serious, complex or rare medical condition. Teledoc Medical Experts will review your care, confirm your diagnosis and recommend treatment.
www.teledoc.com/medical-experts

CONFIDENCE, EXPERIENCE AND THE BEST WORLDWIDE MEDICAL COVERAGE.

At Teledoc Medical Experts we work together with the most renowned leading physicians in their specialty

EMPLOYEE ASSISTANCE PROGRAM (EAP)
Confidential EAP services through OptumHealth are available to you and your family. When you call, you will be connected with a licensed EAP counselor who will help you determine the most appropriate type of assistance needed. The EAP offers a wide range of services including 5 free face-to-face counseling sessions or a referral to community resources.

Counseling Services

- Depression
- Stress
- Co-worker conflicts
- Grief and loss
- Marital or family issues
- Alcohol/substance abuse
- ADHD assessment

Dependent Care Referral

- Child care summer camps
- Elder care and Home health care
- Tips on interviewing and monitoring caregivers
- Relocation and adoption information

Legal Consultation

- Free 30 minute legal consult
- Wills, trusts and estates
- Divorce and custody
- Small claims
- Personal injury
- Real estate transactions
- Drunk driving and criminal offense

Financial Consultation

- Get help with family budget planning or managing your debt from a financial professional

EAP is available 24/7

365 days/year
Call 888-625-4809
www.liveandworkwell.com
Access code: veba

DENTAL PLAN OPTIONS

Good health includes healthy teeth and gums. The dental plans are designed to help you maintain a healthy smile through regular preventive dental care, and to fix any problems as soon as they occur.

You must visit an in-network dentist under the dental HMO plan. If you are enrolled in the PPO, you have the freedom to visit the provider of choice. However, visiting in-network (Delta PPO) providers will save you money on out-of-pocket costs. When you visit out-of-network providers, you are responsible for charges above Delta Dental's contract allowance. Please see the table below for a comparison of dental benefits:

		Delta Dental PPO		Delta Care HMO
		In-Network	**Out-of-Network**	**Primary Care Dental Group or Referred**
Calendar Year Maximum		$2,000/person		N/A
Calendar Year Deductible		None		None
Coinsurance increases annually on January 1 as follows (must visit the dentist annually):				
Routine & Preventive Treatment *Oral exams, X-rays cleanings, fillings, oral surgery*	1st year* 2nd year: 3rd year: 4th year:	Plan pays 70% Plan pays 80% Plan pays 90% Plan pays 100%	Plan pays 70% Plan pays 80% Plan pays 90% Plan pays 100%	No Charge**
Crowns and Pontics		Same as above; limitations may apply		No Charge**
Bridges & Dentures		Plan pays 60% of contract allowance	Plan pays 50% of contract allowance	No Charge**
Implants		Plan pays 60% of contract allowance	Plan pays 50% of contract allowance	Not Covered
Orthodontia	Start-up Fee: Adults: Children (up to age 19):	Not Covered		$350 (excludes records) $1,800 $1,600

** First year or after break in coverage*
*** Additional charges may apply depending upon surface and location. Refer to the full benefit summary for more information.*

Important Note: If you are enrolled in the Delta PPO plan but do not use the plan during the calendar year, the benefit percentage will remain at the level attained the previous year. If you visit the dentist at least once per year, the benefit percentage will increase by 10% per year (to a maximum of 100%). Any break in coverage will revert back to a 70% benefit.

VISION PLAN

Eligible employees have the option to enroll in vision coverage through VSP. As a VSP member, you always have the freedom to visit a non-VSP provider of your choice for a reduced benefit. Your plan includes a reimbursement schedule for services obtained from non-network providers, including national or local chains. When you visit a doctor within the VSP network (in-network) you will receive higher benefits coverage. All providers can contact VSP directly to check eligibility and submit claims on your behalf.

	In-Network	Out-of-Network
Examinations	**Every 12 months**	
• Well Vision Exam • Routine Retinal Screening	$10 copay Plan pays up to $39	Plan pays up to $43
Lenses (for glasses)	**Every 12 months**	
• Single Vision • Lined Bifocal and Trifocal • Standard Progressive	No charge No charge No charge	Plan pays up to $26 Plan pays up to $60 Plan pays up to $43
Frames	**Every 24 months**	
• Hardware/Materials • Standard Allowance	$25 copay $150	Plan pays up to $40
Contact Lenses	**Every 12 months (in lieu of glasses)**	
• Lenses/Materials • Fitting & Evaluation	$25 copay Plan pays up to $120	Plan pays up to $100

PLEASE NOTE:
VSP does not provide ID cards. Simply identify yourself as a VSP member and provide your Social Security number at the time of service.

LIFE AND DISABILITY INSURANCE

Providing economic security for your family if you die, become disabled, or experience an injury or illness is a major consideration in personal financial planning.

$50,000 BASIC LIFE AND AD&D INSURANCE

Eligible employees are automatically enrolled in the District-Paid Term Life insurance through the Harford that provides your beneficiary a benefit if you die while covered as well as the District-Paid AD&D that provides benefits to you or your beneficiary in certain injuries or death resulting from an accident.

Benefits are reduced to 65% at age 65, 50% at age 70 and all coverage cancels at retirement. Be sure to choose a beneficiary to receive benefits in the event of your death.

LONG TERM DISABILITY (LTD) 66 2/3% OF EARNINGS UP TO $7,000/MONTH

Through the Hartford the District-Paid LTD insurance pays you a portion of your earnings if you miss 90 days or more from work if you become disabled from a covered injury, sickness, mental illness, substance abuse or pregnancy.

VOLUNTARY PLANS

SUPPLEMENTAL LIFE/AD&D INSURANCE

Through the Hartford you may purchase additional term life and Accidental Death & Dismemberment (AD&D) insurance coverage for yourself and your eligible family members. Voluntary insurance plans are offered to new hires or during Open Enrollment only.

	Life Insurance Employee	AD&D Insurance
Employee	• Increments of $10,000 to $300,000 (not to exceed 5 times your annual salary) • Benefits Reduce/Term: 50% reduction at age 70 Terms at retirement • Guaranteed Issue: Up to $150,000	• Increments of $10,000 to $300,000 (amounts over $250,000 cannot exceed 10 times your annual salary) • No medical questions necessary for Voluntary AD&D coverage
Spouse*	• 50% of employee voluntary life amount in increments of $5,000 to a max of $100,000 • Benefits Reduce/Term: Terms at age 70 • Guaranteed Issue: Up to $50,000	• 60% of employee voluntary AD&D amount if enrolled as employee + spouse only; or 50% if enrolled as employee + family • No medical questions necessary for Voluntary AD&D coverage
Dependent Children	• If you elect coverage for yourself, you can choose $2,500, $5,000 or $10,000 for each child • Benefits Reduce/Term: Terms at age 26 • Guaranteed Issue: Up to $10,000	• 20% of employee voluntary AD&D amount per child if enrolled as employee + child (ren) only; or 10% per child if enrolled as employee+ family • No medical questions necessary for Voluntary AD&D coverage

**You may not elect coverage for your spouse if they are in active fulltime military service or is already covered as an employee.*

LONG TERM CARE (LTC)

Voluntary LTC with Unum is available for employees, retirees and their eligible family members including spouse or registered domestic partner, parents/in-laws and grandparents/in-laws.

Facility Monthly Benefit	$1,000 - $6,000
Residential Care	60%
Home Care	50%
Family Home Care	50%
Inflation Protection	Simple Growth Capped
Facility Duration	2,4 or unlimited years
Elimination Period	90 days

PRE-PAID LEGAL SERVICES

MetLife provides a voluntary pre-paid legal services plans. Some covered services are:

- Living wills & trusts
- Codicils
- Civil litigation defense
- Identity theft defense
- Uncontested adoptions

If network attorneys are utilized, all covered services are paid in full and there are no deductibles, co-payments, or claim forms. If non-network attorneys are utilized, the member is reimbursed according to a set fee schedule.

Visit https://info.legalplans.com (password 1680005)

Client Service Center is available Monday – Friday 5 a.m. - 5 p.m. PT: 800-821-6400

VOLUNTARY PLANS

ACCIDENT

The Colonial Life Accident plan is a way to stay ahead of the medical and out-of-pocket expenses that add up so quickly after an accident injury. When you have a covered accident, Colonial will send cash benefits directly to you and you decide the best way to spend them. In addition, you are able to receive a payout for obtaining annual preventive health screenings!

HOSPITAL CONFINEMENT

Hospital Confinement insurance can help fill the gaps when you have unexpected health care expenses. This type of insurance can help cover the cost of your deductible, coinsurance, and other out-of-pocket medical expenses.

CANCER

Cancer insurance helps employees and their families maintain financial security in the event of a cancer diagnosis. Employees can choose from four levels of coverage amounts.

SHORT TERM DISABILITY

Short Term Disability income benefits are available on a voluntary basis through Colonial. This coverage provides some income replacement should you be unable to work.

CRITICAL ILLNESS

Critical Illness insurance helps you and your family maintain financial security during the lengthy, expensive recovery period of a critical illness by providing a lump sum benefit to help with the out-of-pocket medical and non-medical expenses.

ENROLLMENT:

To enroll contact Brian Akian at 714-609-1605 or email Brian.Akian@ColonialLifeSales.com

VOLUNTARY PLANS

PET INSURANCE

You ensure that you and your family are covered by health insurance, but what about our furry family members? Pet insurance provides a financial safety net for unexpected veterinary expenses. This plan may provide coverage for chronic and recurring conditions (that are not pre-existing) at no out-of-pocket cost including accident, illnesses, injuries, diseases including cancer, medications, diagnostic testing, surgery, hospitalizations and more.

Coverage options:

- Cash back for routine services that help keep your pet healthy such as wellness exams, shots, flea/tick/heartworm protection, dental cleanings, spay/neuters
- Annual deductibles of $100, $250 or $500
- Annual benefit limits of $5,000, $10,000, $15,000, $20,000 or unlimited
- Reimbursement ranges of 70%-90%

Add Preventive Care: For a little more per month, get reimbursed up to the scheduled amount for dental cleanings, heartworms, flea prevention, and more. No deductible, co-pay, or waiting period – just cash back for things that keep pets healthy.

Eligibility: All cats and dogs 8 weeks and older.

No Networks: Visit any vet or emergency clinic.

Premiums: Policy premiums are based individually on each pet by age and breed.

Premium Payment: Billed directly to the employee by the provider.

GROUP HOME & AUTO INSURANCE

Liberty Mutual's Auto & Home group insurance program is available to you as a voluntary benefit through GCCCD.

Payroll deductions are not available. Employees set-up direct pay or automatic withdrawals with Liberty Mutual. Employees qualify for the educators discount on home and auto rates. Also, the GCCCD Plans receive enhanced insurance coverage, unlike outside insurance companies, at no additional cost:

- Quality auto and home coverage, expert advice, and personalized service at a fair price
- Easy enrollment (direct bill to Liberty Mutual)
- Rates guaranteed for 12 months
- Dedicated account management team
- Educators Exclusive Benefits Auto Insurance
  - » Vandalism Loss Protection – If your vehicle is vandalized on school property or during school-related events, there is a $0 deductible.
  - » Personal Property Coverage – If your teaching materials or school-owned property is stolen or damaged while in your vehicle, you're covered up to $2,500 per occurrence.
  - » Collision Coverage – There is $0 deductible if your vehicle is damaged in a collision while you're driving it on school business.

ENROLLMENT:

To enroll, go to libertymutual.com/gcccd or contact Susanne Schaible at 858-255-3973 or email Susanne.Schaible@LibertyMutual.com

FLEXIBLE SPENDING ACCOUNT

A great way to save money over the course of a year is to participate in the Flexible Spending Accounts (FSA) through TASC. These accounts allow you to redirect a portion of your salary on a pre-tax basis into reimbursement accounts. Money from these accounts is then used to pay eligible out-of-pocket expenses such as health care deductibles, copays, prescription, and dependent care expenses.

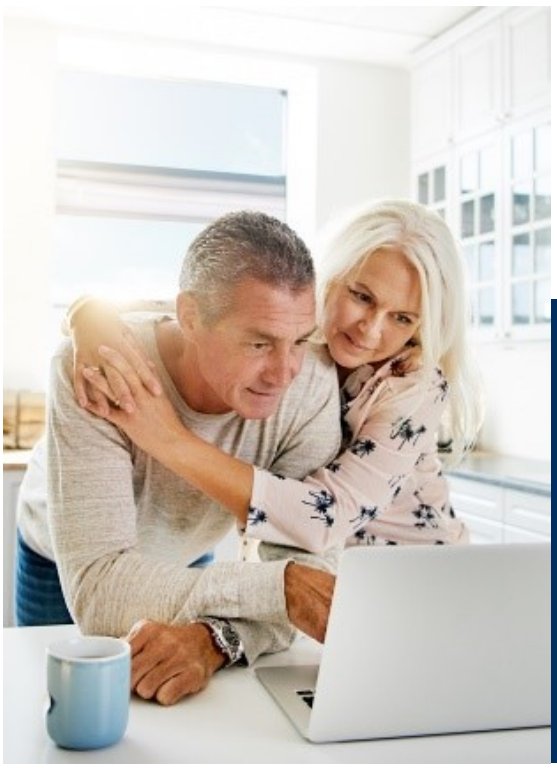
Pre-tax means the dollars you use for eligible expenses are not subject to Social Security tax, federal income tax and, in most cases, state and local taxes. Money you would have paid in taxes can be used to pay qualified expenses.

There are two accounts: Health Care Spending Account and the Dependent Care Spending Account. You may use either account, or both. When you enroll, you decide how much money to contribute to your personal accounts for the coming year. These contributions are gradually deducted from your paycheck through the year and deposited into your account.

HEALTH CARE ACCOUNT

This account will reimburse you with pre-tax dollars for health care expenses not reimbursed under your family's health care plans. The minimum amount you may contribute to a Health Care Spending Account for the plan year is $100; the maximum is $2,750.

Please note: You must save your itemized receipts for all debit card purchases in case you are asked to provide them for substantiation, per IRS guidelines.



DEPENDENT CARE ACCOUNT

This account will reimburse you with pre-tax dollars for day care expenses for your child(ren) and other qualifying dependents. The minimum amount you may contribute to a Dependent Care Spending Account for the plan year is $100; the maximum is $5,000, or $2,500 if you are married and file separate tax returns.

Eligible dependents include:

- Children under the age of 13 who qualify as dependents on your federal tax return; and
- Children or other dependents of any age who are physically or mentally unable to care for themselves and who qualify as dependents on your federal tax return.

IMPORTANT!

Your FSA elections must be made annually during Open Enrollment. Your selections from the previous year do not carry over automatically.

FLEXIBLE SPENDING ACCOUNT

HOW YOUR FSA ACCOUNTS WORK

Each year during the Open Enrollment period, you decide how much you want to contribute to your health care and dependent care spending account(s) for the plan year.

At the start of the plan year each pay period, money is deducted from your paycheck in equal increments before taxes. These funds are contributed to your health care and/or dependent care spending account(s), thus saving you tax dollars.

As a participant of the FSA plan, you will be provided an FSA debit card. This card is linked to your FSA account. When purchasing qualified health care services or products, simply use your FSA debit card and the transaction is complete. You must save your itemized receipts for all debit card purchases in case you are asked to provide them for substantiation as per IRS guidelines.

When you have an eligible dependent care or health care expense and need to submit a claim form for reimbursement, you may submit a request to FlexSystem using one of the following methods:

- Submit via MyTASC Mobile App
- Submit via MyTASCText Message (SMS)
- Download a Request for Reimbursement form online at www.tasconline.com

BE CAUTIOUS!

- Only qualifying health care and dependent care expenses incurred during the 2022 plan year will be eligible for reimbursement.
- Dependent care funds are available for reimbursement only as they are deducted from your paychecks and contributed to the plan (money-in, money-out).
- Use it or lose it. Money in the accounts must be claimed within 90 days after the end of the plan year or it will be forfeited.

ANNUAL GRACE PERIOD

If at the end of your plan year you have a balance in your account, you will have until March 15, 2023 to incur expenses and use the funds and until March 31st to submit claims. After March 31st, any funds that are left in your account will then be subject to the "use it or lose it" rule and be forfeited.

Once you enroll, you can only change your elected payroll deduction if there is a change in family status, such as marriage, divorce, death, birth, adoption, or change in employment status.

If you are no longer working for GCCCD, you can continue to submit requests for expenses incurred up to your date of separation. Please note, all requests for reimbursement must be received within 90 days of your last day worked at GCCCD.

Upon review and approval of the eligible expenses submitted to FSA, you will be reimbursed for the expense(s).

MY TASC

offers a variety of ways to manage your Flexible Spending Accounts!

- Online: www.tasconline.com
- MyTASC Mobile application
- Text messaging

DEFERRED COMPENSATION PLANS

403(B)/457(B) PLANS

The Fringe Benefits Consortium (FBC) Deferred Compensation Program is a retirement program designed to help educators build and grow their savings in order to achieve their retirement dreams.

What are 403(b), 457(b) & ROTH 403(b) plans?
403(b) or 457(b) refer to a section in the IRS Code that allows you to save part of your income on a PRE-TAX basis. This lowers your current taxable income and can help your long-term savings grow faster. Your 403(b) and 457(b) savings will not be taxed until withdrawn.

The Roth 403(b) plan enables you to save part of your income on an AFTER-TAX basis. Your Roth 403 (b) savings may be withdrawn tax-free.

When can I withdraw the money?
Money may be withdrawn from your account in these events occur:

403(b) & Roth 403(b)	457(b)
Termination of Employment	Termination of Employment
Attaining age 59½	Attaining age 59½
Hardship	Unforeseeable emergency
Death	Death
Disability	Disability
Age 72 required distribution	Age 72 required distribution

How much money can I defer into these plans?
For the 2022 tax year the elective deferral contribution limits for employees who participate in 403(b) and 457(b) plans has been set at $20,500 by the IRS.

What are "catch-up" contributions?
The catch-up contribution provision allows you to save up to an additional $6,500 during the 2022 tax year if you are over age 50. Furthermore, if you have 15 years of service with the District, you may also be eligible to make an additional $3,000 catch-up contribution to the 403(b) plan and if you are in your final 3 years prior to reaching Normal Retirement Age, you may be eligible to contribute up to an additional $15,000 to the 457(b) plan.

May I transfer money between the plans?
If you have an existing qualified retirement plan (pre - tax), 403(b) tax-deferred arrangement or governmental 457(b) plan with a prior employer, or hold a Tax-Deferred IRA account, you may transfer or roll over that account into the Plan anytime. Contact the SchoolsFirst customer service center at 800-462-8328.

RESOURCE CENTER:

FRINGE BENEFITS CONSORTIUM

www.fbc-retire.com. Learn about saving and investing topics, calculate your potential account growth and keep up-to-date with current issues and aspects related to retirement planning.

FBC RETIREMENT PLAN ADVISOR:

John Ma 619-430-0711
Email: john.ma@empower-retirement.com

Retirement Specialists are salaried and noncommissioned, and will make no offer to sell any products, thereby maintaining focus strictly to the program.

SCHOOLSFIRST PLAN ADMINISTRATION, LLC

Enrollment and deferral changes: create an account and log into https://pa.schoolsfirstfcu.org/

Access forms: https://schoolsfirstfcu.org/ then select the "Investments & Retirement" tab.

FIND A PROVIDER

MEDICAL PLANS

Kaiser Permanente

Go to www.kp.org

- Choose Your Region • California - Southern
- Scroll down and click on Find Doctors & Locations
- Search by Location or Hospital/Doctor's Name

Your PCP and locations can be different than your covered dependents.

UnitedHealthcare

Go to www.welcometouhc.com/csveba

- Scroll down to choose the plan/network:
  - » **Signature Value Harmony**
  - » **Performance HMO:** "CS VEBA Performance HMO" – select Network 1, 2 or 3. You can change PCPs within your network but you cannot change networks during the year
  - » **Signature Value CS VEBA Alliance** (Alliance HMO 1200 HRA or Alliance HMO 20/30)
- Click the "X" in the top right corner
- Enter Zip Code

UMR

Nexus ACO PPO Go to www.umr.com

- Click on Find a Provider
- Choose provider network
  - » United Healthcare Nexus ACO
- Search by provider type
- Enter Zip Code
- Providers with Tier 1 designation will have the Tier 1 symbol on their profile:

SIMNSA

Go to www.simnsa.com

- Click on "Providers & Facilities"
- Select Network, Type of Doctor, and/or Specialty to Start Search

CHIROPRACTIC & ACUPUNCTURE

Optum

Go to www.myoptumhealthphysicalhealthofca.com

- Click on Provider Locator
- Choose "California Schools VEBA" in the Plan/Product drop down box

You can also call OptumHealth Member Services at 800-428-6337 (5am to 5pm PT, M – F) or call the provider directly to verify they are part of the OptumHealth network for VEBA.

DENTAL PLANS

Delta Dental

Go to www.deltadentalins.com

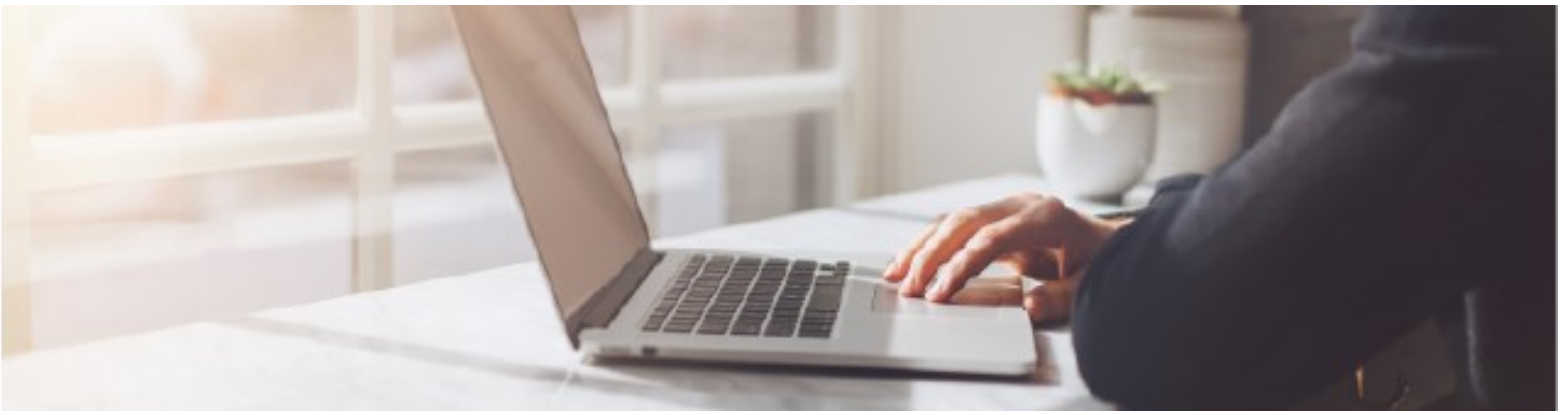
- Click "Find a Dentist"
- Enter Location Zip Code or City
- Choose the plan/network
  - » **Delta Dental DHMO:** "DeltaCare USA"
  - » **Delta Dental PPO:** "Delta Dental PPO"
    PPO dentists have agreed to reduced contracted rates and can't balance bill you for additional fees. Non-PPO "Premier" dentists offer broader access to dental care without the worry of balance billing
- Other Non-PPO dentists set their own prices and you may be responsible for balance billed amounts higher than the plan allowance.
- Search by dentist, practice or keyword
- Click "Search"

VISION PLAN

VSP

Go to www.vsp.com

- Click "Find a Doctor"
- Enter Location Zip Code
- Click "Search"



CONTACT INFORMATION

	Phone	Online	Policy #/ Reference
Kaiser HMO	800-464-4000	www.kp.org	Medical record # on Kaiser ID card
UnitedHealthcare (UHC) HMO Member Services UMR Nexus PPO Member Srvcs Express Scripts Inside Rx Pets	 888-586-6365 800-826-9781 800-918-8011 800-722-8979	 www.myuhc.com www.umr.com www.expressscripts.com https://insiderxpets.com/	 UHC ID card UHC/UMR ID card ESI ID card
VEBA Programs Advocacy & Wellness Teledoc Medical Experts	 888-276-0250 866-904-0910	 www.vebaonline.com www.teledoc.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: 01 800 800-1491 Mexicali: 686-555-6322	www.simnsa.com	
Optum Health EAP 24-7 Referrals	888-625-4809	www.liveandworkwell.com	access code: veba
Delta Dental DHMO Member Services PPO Member Services	 800-422-4234 800-765-6003	www.deltadentalins.com	
VSP Vision Plan	800-877-7195	www.vsp.com	121832780
The Hartford Basic & Supplemental Life Supplemental AD&D Long Term Disability	 800-231-5453 800-231-5453 877-778-1383	www.thehartford.com	875040 S07819 Plan A 875040
TASC FSA	800-422-4661	www.tasconline.com	GCCCD
Unum Long Term Care Enrollment Member Services	Claims: 800-633-7479 800-227-4165 800-421-0344	www.unuminfo.com/consortium	105237
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
Liberty Mutual Auto & Home Insurance Pet Discount Program	 858-255-3973 858-255-3973	https://www.libertymutual.com/gcccd Susanne.Schaible@LibertyMutual.com	136348
FBC Deferred Compensation Plan SchoolsFirst Customer Service Retirement Plan Advisor	 800-462-8328 John Ma 619-430-0711	https://fbc-retire.com/ https://pa.schoolsfirstfcu.org/ john.ma@empower-retirement.com	GCCCD
Human Resources Benefits Technician	619-644-7643	www.gcccd.edu/benefits/default.html	
Benefits Advocate McGriff Insurance Services	800-914-5096	BenefitsAdvocate@McGriff.com	GCCCD

REQUIRED NOTICES

The following is a brief description of the Annual Disclosure Notices that ERISA and various other state and federal laws require that employers provide annually to eligible plan participants. Please refer to GCCCD'S benefits website for a copy of the full disclosures.

Children's Health Insurance Program (CHIP)
If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. This notice provides information on how to contact your state Medicaid office to receive information on assistance.

HIPAA Opt-Out
Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy.

Health Insurance Marketplace Coverage Options
Beginning in 2014, there were new ways to buy health insurance: the Health Insurance Marketplace. This notice provides basic information about the Marketplace.

Continuation Coverage Rights Under COBRA
This notice 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. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

Employee Leave Entitlements
Under FMLA, eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12- month period for the following reasons:

- Birth of a child or placement of a child for adoption/foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.
- This notice provides information regarding benefits & protections, eligibility, requesting leave, employer responsibilities and enforcement.

Uniformed Services Employment and Reemployment Rights Act (USERRA)
USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating

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

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

Patient Protection Notice
Your plan generally allows the designation of a primary care provider. 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.

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

Wellness Program Disclosures (ADA/GINA/HIPAA)
The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act (ADA) of 1990, the Genetic Information Nondiscrimination Act (GINA) of 2008, and the Health Insurance Portability and Accountability Act (HIPAA), as applicable, among others. If you choose to participate in the wellness program you may be asked to submit a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You might also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the inquiries or to participate in tests or other medical examinations.

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

NOTES

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NOTES

2022

BENEFITS GUIDE

CSEA, Local 707 Administrators Association

Grossmont-Cuyamaca
Community College District