HUMAN RESOURCES

BENEFITS GUIDE 2027

WEST VALLEY-MISSION COMMUNITY COLLEGE DISTRICT

2027 BENEFIT HIGHLIGHTS

CalPERS medical plan option changes effective January 1, 2027

- **Removal** of UnitedHealthcare HMO plans: Alliance and Harmony
- **Addition** of Sutter Health HMO plan
  - > **Available only in these counties: Placer, Sacramento, San Joaquin, Stanislaus, Solano, Yolo**
- **Infertility Benefit Effective July 1, 2027**

  Effective July 1, 2027, CalPERS medical plans will include coverage for diagnosis and treatment of infertility. More information to come!

Significant benefit coverage improvement in the Delta Dental PPO plan effective January 1, 2027

The increased cost to make these improvements is 100% covered by the District

- **Annual maximum benefit increase**

  Currently, the Delta Dental PPO plan pays benefits up to an annual maximum of **$2,000** per covered member. Once that maximum is reached, any additional eligible dental expenses are the member's responsibility for the remainder of the plan year. With this upgrade, the annual maximum benefit will increase from **$2,000 to $6,000**, providing significantly greater coverage before members become responsible for additional costs.
- **Immediate access to full benefits for preventive and basic care**

  Currently, full benefits are phased in over a three-year period. With this enhancement, members will have access to the plan's full benefits from their **first** year of coverage.
- **Higher reimbursement levels to dental providers for dental services**

  Delta Dental will now base covered procedure reimbursements on the typical costs charged in our **local region**, rather than a statewide average.
  Because dental care costs in our area are generally higher than in many other parts of California, this enhancement will help ensure that plan reimbursements more closely reflect the actual cost of care, **reducing out-of-pocket expenses for members**.

2027 District Contribution

The District has increased its contribution for 2027 and continues to offer several bundled medical/dental/vision options that are a **$0 payroll contribution** for employee only or employee with dependents.

Online Enrollment Platform

PlanSource is the new platform for benefits enrollment.

Flexible Spending Accounts

PlanSource is the new administrator for FSA and Commuter plans. See page 20 for new limits.

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West Valley-Mission Community College District (WVMCCD) truly appreciates the contributions our employees make to cultivate a community of learning and success! That's why we provide a comprehensive benefits program and are committed to providing you with benefits that meet the needs of you and your family. We offer a range of plans that help protect you in the case of illness or injury. This Benefits Guide is a comprehensive tool to help you become familiar with the plans and programs that you and your family can enroll in for the plan year. WVMCCD recognizes the importance of benefits for you and your family, that's why we take the time to carefully select providers that can best serve our employees. We know you don't make your benefit decisions lightly, which is why we are dedicated to partnering with providers who offer quality benefits.

BENEFITS ADVOCATE

McGriff
A Marsh & McLennan Agency LLC Company

Benefits Advocate is available to assist you with your benefits-related questions and issues. When there is confusion or concern with your insurance, reach out to Benefits Advocate for assistance. This service is brought to you by McGriff, a Marsh & McLennan Agency LLC Company.

(800) 914-5096

mcg.benefitsadvocate@marshmma.com

Monday – Friday, 8:00 a.m. – 5:00 p.m. Pacific Time
except major holidays

ELIGIBILITY

You are eligible for the benefits program if you meet the minimum eligible employee guidelines as defined by West Valley-Mission College Community College District. You are eligible for benefits with WVMCCD the first of the month following your date of hire. Your eligible dependents are defined as:

- Legally married spouses
- Qualified domestic partners
- Children up to age 26
- Parent Child Relationship as defined by CalPERS for the medical plan
- Stepchildren
- Legally adopted children
- Disabled children (approved by CalPERS/no age maximum)
- Children of qualified Domestic Partnerships
- Any child for whom a Qualified Medical Child Support Order that complies with all applicable laws has been issued

Certification of Dependents for Health Plan Coverage

- To enroll your spouse, you must provide a copy of the Marriage Certificate
- To enroll your domestic partner, you must provide a copy of the California Declaration of Domestic Partnership filed with the Secretary of State
- To enroll children, you must provide one of the following:
  a. Copy of Birth Certificate
  b. Copy of Adoption Papers

Before enrolling anyone as your dependent, verify that he or she qualifies under the plan rules. Enrolling an ineligible person as your dependent is a serious offense that will result in disciplinary action, which may include termination of employment.

CASH IN LIEU OF MEDICAL BENEFITS

Upon providing proof of coverage in another group health plan, employees of West Valley-Mission Community College District have the option to decline the district medical insurance and receive cash in lieu.

Employees may choose to deposit the cash into a Tax Shelter Annuity 403(b), 457 plan or receive the cash as an addition to pay. Please note that this benefit will be subject to income tax. If you choose to deposit the contribution into a 403(b) or 457 plan, the only taxes that will be deducted are FICA (Social Security) and Medicare.

$4,800

Annually

Qualifying employees will receive the cash in lieu amount prorated by pay period.

MAKING CHANGES DURING THE YEAR

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

- Change in marital status
- Change in number of dependents (birth, adoption, death)
- Change in spouse or dependent's eligibility under an employer's plan
- Change in employment status that changes eligibility status (change in work schedule such as termination, a decrease in hours worked, change in residency that affects accessibility to current plan)
- Change in cost or coverage (significant cost increase, open enrollment of spouse under another employer's plan)
- Change in eligibility for a state program such as Medicaid

MEDICAL Coverage: When you experience a **family** or **employment** status change, the benefit changes you request must be made **within 60 days** of the event and must be consistent with and due to your change in status. The effective date is the first of the month following the date the request is received by the Benefits Specialist in Human Resources. For example, if your newborn child is born on November 15th and you submit the change to HR by November 30th, the newborn's coverage would become effective on the plan December 1st. If you miss the 60-day deadline, your dependent would not be eligible for coverage until the next open enrollment period. If you need assistance determining what changes are allowed, contact Human Resources. Any benefit change needed due to a loss of **Medicaid/CHIP** coverage or gaining eligibility for a state's premium assistance program under **Medicaid or CHIP** must be made **within 60 days** of the event.

NON-MEDICAL Coverage: While your qualifying event may affect both medical and non-medical plans, you are encouraged to report **within 30 days** of the event to make changes in a timely manner in a non-medical plan.

IMPORTANT: In the event of a divorce, employees must notify the district **within 30 days** to remove the ex-spouse from benefits. Employees may want to consider making beneficiary changes at the same time.

Exceptions: You may enroll in a voluntary retirement plan at any time throughout the year. You may apply for MetLife voluntary life insurance at any time throughout the year, however, if you apply outside of your 30-day new hire window, you will be required to complete a Statement of Health. MetLife will approve or deny your request for coverage. See page 18 for more information about enrolling in life insurance outside of your new hire window.

OPEN ENROLLMENT

Each year, you will have the opportunity during Open Enrollment to make changes to your plan(s) without a qualifying event required. This period usually runs from mid-September through mid-October. Changes you make are effective the following January 1st.

The coverage(s) you elect during Open Enrollment are in force for the entire plan year, January 1 through December 31, unless you experience a qualifying life event.

Planning to retire?

If you are participating in cash-in-lieu and are eligible for early retiree health benefits, you must enroll in the medical plan during open enrollment and be covered at the time of your retirement from the district.

HOW TO ENROLL

All enrollments are completed online via our online benefits administration system, PlanSource. You must complete all of your enrollments by the end of the month in which you are hired. If you try to enroll after the deadline, your medical coverage start date may be delayed or you may not be able to enroll in coverage until the next open enrollment period, unless you experience a qualifying life event. See *Making Changes During the Year* for details. The voluntary retirement plans are an exception as you may enroll in a 403(b) or 457 at any time. Benefit plan information is located on the district website within the Human Resources page.

PLANSOURCE ONLINE ENROLLMENT INSTRUCTIONS

PlanSource is our online enrollment tool that is available 24 hours a day, 7 days a week. This system allows you to elect your benefit choices as a new hire or during Open Enrollment, or when you have a life event. After enrollment, PlanSource is available year-round to check your benefits information.

When you are ready to choose your benefits, the first step is logging into the benefits enrollment website.

1. Go to **https://thesource.plansource.com/westvalleymissioncommunity/login**
2. Enter your **username** and **password**
   - When logging in for the first time, you will use your date of birth as your initial password. You will then be prompted to change that password.
3. Click **Login**

As part of your enrollment process, be sure to review your **Profile** and update as needed. Under **Manage My Family**, you can add family members so that they will be on a list to choose from when you are adding a dependent to your benefits.

At the top of the screen, you will see links to the main sections: Profile, Benefits, Financial and Details. You can click any of these at any time to go back and review or update your information.

PlanSource makes this easy for you by providing you an "online shopping experience". You can add or remove items from your "cart". A tally of your cost is also shown as your cart changes. Once you are happy with your selections, you will then click on **Checkout** and **Confirm** to complete the process.

To assist, a detailed enrollment guide is available on the Human Resources website at **XX**.

Username

Banner ID Number (G0 + employee ID)

Initial Password

Date of Birth in YYYYMMDD format

CONTRIBUTIONS

Contributions for medical, dental and vision coverage are conveniently deducted from your paycheck on your pay period schedule. These deductions are on a pre-tax basis which gives you a tax savings benefit as your paycheck is taxed on your gross pay minus the contribution.

Review the following to understand how your contribution is calculated.

How much money does the District contribute to my health plan costs?

The District contribution toward your annual benefits is a maximum of the amounts below to be used toward Medical, Dental and Vision coverage.

$18,596
employee only

$35,247
employee + 1

$45,238
employee + 2 or more

How much money will I contribute to my health plan costs?

Your cost share will depend on the choices you make for your coverage and if you elect to enroll one or more dependents on your plan. If the annual costs of your elections exceeds the annual District contribution listed above, you will be responsible for the difference. The calculated amount will be charged to you per pay period.

Contribution Example

Below is an example based on hypothetical costs for medical, dental and vision.

Employee Only Coverage	
	Annual Costs
ABC Medical	$18,596
XYZ Dental	$700.00
123 Vision	$200.00
Annual Total	$19,496

Contribution Calculation	
Employee Annual Election Costs	$19,496
Minus Annual District Contribution	$18,596
Annual Difference	$900
If paid over 10 months, contribution is:	$90.00

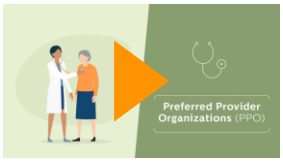
MEDICAL PLANS OVERVIEW

West Valley-Mission Community College District offers you medical plan choices designed to help you get the care you need at a price you can afford. Review the sections below to gain an understanding on the medical plans offered to you through CalPERS. Click on the play button (▶) in the images to watch a short video.

What is an HMO?

A Health Maintenance Organization (HMO) plan provides health care from specific doctors and hospitals under contract with the plan. In an HMO, you select a primary care physician (PCP) from the network of providers who will coordinate your health care needs, refer you to specialists (if needed) and approve further medical treatments. Each enrolled family member may select a different PCP. Services outside of the HMO network are not covered, except in the case of emergency medical care.

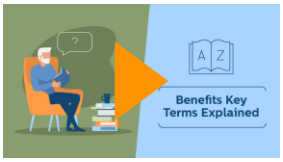
What is a PPO?



A Preferred Provider Organization (PPO) plan gives you the freedom to seek care from a provider of your choice and to see a specialist without a referral. Members in the PERS Gold and PERS Platinum plans will be matched to a Primary Care Physician (PCP). An assigned PCP will not change a member's ability to self-refer to a specialist. A PCP can be changed at any time.

You will maximize your benefits and reduce your out-of-pocket costs if you choose a provider who are established as "in-network" providers. The plan pays a percentage of the "maximum allowed amount" and you will not be responsible for any balance-billing for charges above the maximum allowed amount. When you have services that are out-of-network and with non-PPO preferred providers, you will pay higher costs out-of-pocket. You may also be subject to balance-billing as non-contracted providers are not limited to the maximum allowed amount.

What Is Your Cost For Services?



Your HMO and PPO plans will cover your preventive care service 100% when your care is with in-network providers.

Outside of preventive care, you will have a share in the cost of your service. Your share can be in any of these forms:

- **copay** – a flat dollar amount
- **coinsurance** – a percentage of the cost
- **deductible** – an amount to meet before the insurance plan pays for coverage

Your plan also protects you from very costly services by putting a limit on the most you would pay for all covered services in a calendar year. This is called the **out-of-pocket-maximum**.

Whether your use your plan frequently or not at all, you must pay the **premium** to have medical coverage. Your premium is paid through a convenient payroll deduction.

THINGS TO CONSIDER WHEN CHOOSING BETWEEN HMO AND PPO

Can you afford a payroll contribution?

Compare the cost of the HMO and the PPO plans. If you cannot afford a payroll contribution, consider one of the lower premium HMO plans.

Can you afford the deductible?

Compare the deductible that you must meet first for certain services before your insurance will begin to cover. In the PPO – a deductible is required for most services outside of an office visit.

If you already have a doctor you like, does the plan you are considering cover visits with your provider and/or specialist?

If you would like to keep your medical provider/group, you can determine whether your doctor is in-network under an HMO plan, a PPO plan or both.

With CalPERS, the HMO plans have the same coverage for most services. The difference between the HMO plan options is the carrier you choose, the premium cost of that plan and the network of providers. If deciding to enroll with an HMO, carefully review that your provider of choice is in the network with that carrier. **Your search is based on the zip code you enter which can be your home address or your work address.**

Do you have dependents that live in another state?

When dependents live outside the service area, they are only covered for emergency services in an HMO plan. If you have a child in college that resides outside of the HMO service area, the PPO plan will be a solution to consider to ensure coverage for you and all your dependents regardless of where they live in the U.S.

NOTE: With CalPERS, only PERS Platinum PPO has a network outside of CA. The PERS Gold PPO plan only has coverage in CA.

Do you stay close to home, or do you travel a lot?

If you travel frequently and are more likely to need care while away from home, especially if you are living with a chronic condition, or enjoy high-risk hobbies such as certain sports, you may need a PPO to provide the best coverage for your needs.

If you need a lot of specialist care, say you are managing a rare or chronic condition, you may also prefer the ease of choosing specialists and seeing them right away that you get with a PPO plan.

If you mostly get care in your home city or mostly from your family physician, an HMO is more likely to provide the right coverage for you.

CHOOSING A MEDICAL PLAN

CalPERS gives you many plan options to choose from, and it can seem overwhelming. We have created the following steps to help you work through what to consider and how to get to an informed decision.

PLAN AVAILABILITY

Not all plans may be available to you. To find CalPERS health plans available in your area, use the **Health Plan Search by Zip Code** tool. Log in at www.**calpers.ca.gov** and select **Active Members** tab then **Health Benefits** tab and then select **Plans & Rates**. When on this page, find on the right-hand side the **Health Plan Search by Zip Code** tool. You may choose to search by your home address or your work address to view available plans.

PLAN COST

Each insurance carrier charges a "premium" to be enrolled in the plan. The District will contribute towards that premium. If there is a difference, you pay the remainder via a payroll deduction. Below is a simple chart to show you the plan costs in relation to each other. Review the Human Resources website to find exact details.

HMO plans from least cost to most cost. Plans with an asterisk signifies a limited provider network.

PPO plans from least cost to most cost.

PROVIDER SEARCH

Instructions are included at the end of this guide to search for providers in each medical plan. You should conduct a search for your primary care physician, any specialist you wish to see and the preferred hospital that you wish to attend.

HMO plans – When choosing an HMO plan, remember that your assigned physician and any specialist they refer you to must be in-network for your insurance plan to cover.

PPO plans – The CalPERS PPO **Gold** plan is available if you live in California and all your services will be in California. Services outside of California will not be covered. The CalPERS PPO **Platinum** plan has a national network of providers and will cover eligible services in California and outside of California.

PLAN COVERAGE

Plan design, or plan coverage, is simply what the insurance carrier will cover for an eligible expense. This is often shown as your share of the cost for the visit. For all plans, a preventive care visit is at no charge when seeing an in-network provider.

HMO plans – The HMO plan options were designed to have the same coverage for most services.

Your costs are predictable as most services are covered with a flat copay amount.

HMO Plans	In-Network Only
Routine Office Visits	You pay $15
Inpatient Hospitalization	You pay $0
Emergency Room Visit	You pay $50
Generic Rx (30-day supply)	You pay $5

PPO plans – The PPO plans offer more freedom to see a provider of your choice, but you typically have more share in the cost of the visit before insurance will cover.

Your costs are not as predictable as you must first meet a deductible for most services then pay a percentage of the cost thereafter.

PERS PPO Gold	In-Network	Out-of-Network
Deductible	$1,000 individual $2,000 family	$2,500 individual $5,000 family
Routine Office Visits	You pay $35	You pay 40% after you have paid the deductible
Inpatient Hospitalization	You pay 20% after you have paid the deductible	
Emergency Room Visit	You pay $50 and 20% after you have paid the deductible	
Generic Rx (30-day supply)	You pay $5	

PERS PPO Platinum	In-Network	Out-of-Network
Deductible	$500 individual $1,000 family	$2,000 individual $4,000 family
Routine Office Visits	You pay $20	You pay 40% after you have paid the deductible (For inpatient hospitalization, you also pay $250 in addition)
Inpatient Hospitalization	You pay $250 and 10% after you have paid the deductible	
Emergency Room Visit	You pay $50 and 10% after you have paid the deductible	
Generic Rx (30-day supply)	You pay $5	

HMO MEDICAL COVERAGE

CalPERS	Anthem Select	Anthem Traditional	Blue Shield Access+	Blue Shield Trio	Kaiser Traditional	Sutter Health [1]
In-Network Only						
Annual Deductible	None	None	None	None	None	None
Routine & Specialist Office Visit	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay
Preventive Care Services	No charge	No charge	No charge	No charge	No charge	No charge
Urgent Care Visit	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay
Emergency Room Visit	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay
Diagnostic X-Ray / Lab	No charge	No charge	No charge	No charge	No charge	No charge
Durable Medical Equipment	No charge	No charge	No charge	No charge	No charge	No charge
Inpatient Hospitalization	No charge	No charge	No charge	No charge	No charge	No charge
Outpatient Facility / Surgery Services	No charge	No charge	No charge	No charge	$15 copay	No charge
Surgery / Anesthesia	No charge	No charge	No charge	No charge	No charge	No charge
Occupational / Physical / Speech Therapy	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay
Acupuncture / Chiropractic	$15 copay 20 combined visits	$15 copay 20 combined visits	$15 copay 20 combined visit	$15 copay 20 combined visit	$15 copay 20 combined visits	$15 copay 20 combined visits
Infertility Testing / Treatment	50% of covered charges	50% of covered charges	50% of covered charges	50% of covered charges	50% of covered charges	50% of covered charges
Max Calendar Year Copay/Coinsurance (excluding pharmacy)	$1,500 ind $3,000 fam	$1,500 ind $3,000 fam	$1,500 ind $3,000 fam	$1,500 ind $3,000 fam	$1,500 ind $3,000 fam	$1,500 ind $3,000 fam
Prescription Drugs (Tier 1 | Tier 2 | Tier 3 | Tier 4)						
30-day supply Retail Pharmacy [2]	$5 | $20 | $50 | NA	$5 | $20 | $50 | NA	$5 | $20 | $50 | $30	$5 | $20 | $50 | $30	$5 | $20 | NA | NA	$5 | $20 | $50 | NA
90-day supply Retail Pharmacy OR Mail Order Pharmacy	$10 | $40 | $100 | NA	$10 | $40 | $100 | $60	$10 | $40 | $100 | $60	$10 | $40 | $100 | NA	$10 | $40 | $100 | NA (Mail order is 31-100 day and Tier 3 is NA)	$10 | $40 | $100 | NA

Above is a snapshot summary. Refer to the plan's Evidence of Coverage (EOC) for the full summary of coverage information.

[1] Sutter Health HMO is only available in these counties: **Placer, Sacramento, San Joaquin, Stanislaus, Solano, Yolo**

[2] Review your plan to ensure if Retail Pharmacy Maintenance Medications require a Home Delivery Opt-Out form to be completed to continue to have prescriptions filled at retail. Plans that do not require Home Delivery for Maintenance Medications may be subject to a higher copay after the 2nd fill.

NOTE: Only plans available in Santa Clara, San Mateo, Alameda, Contra Costa and San Francisco counties are shown. If you live in another county, please use the Health Plan Search by Zip Code tool referred to on page 10 to determine if any other options are available to you.

PPO MEDICAL COVERAGE

CalPERS	PERS Gold		PERS Platinum		PORAC (for dues paying police officers only)	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Annual Deductible	$1,000 ind [1] $2,000 fam [1]	$2,500 ind $5,000 fam	$500 ind $1,000 fam	$2,000 ind $4,000 fam	$300 ind $900 fam	$600 ind $1,800 fam
Routine & Specialist Office Visit	$35 [2]	40%	$20/$35	40%	$10/$35	20%
Preventive Care Services	No charge	40%	No charge	40%	No charge	No charge
Urgent Care Visit	$35	40%	$35	40%	$35	20%
Emergency Room Visit	20% + $50 copay per visit		10% + $50 copay per visit		20%	20%
Diagnostic X-Ray / Lab	20%	40%	10%	40%	20%	20%
Durable Medical Equipment	20%	40%	10%	40%	20%	20%
Inpatient Hospitalization	20%	40%	10% + $250 per admit	40% + $250 per admit	20%	20%
Outpatient Facility / Surgery Services	20%	40%	10%	40%	20%	20%
Surgery / Anesthesia	20%	40%	10%	40%	20%	20%
Occupational / Physical / Speech Therapy	20%	20% occupational 40% all others	10%	10% occupational 40% all others	$15 occ/phy 20% all others	20%
Acupuncture / Chiropractic	$15 copay 20 combined visits	40%	$15 copay 20 combined visit	40%	$15 copay Chiro up to 20 visits	20%
Infertility Testing / Treatment	50% of covered charges	50% of covered charges	50% of covered charges	50% of covered charges	50% of covered charges	50% of covered charges
Max Calendar Year Coinsurance (excluding pharmacy)	$3,000 ind $6,000 fam	No limit	$2,000 ind $4,000 fam	No limit	NA	NA
Max Calendar Year Out-of-Pocket (excluding pharmacy)	$7,200 ind $14,400 fam	No limit	$7,200 ind $14,400 fam	No limit	$2,000 ind $4,000 fam	$2,000 ind $4,000 fam
Prescription Drugs (Tier 1 | Tier 2 | Tier 3)						
30-day supply Retail Pharmacy **	$5 | $20 | $50		$5 | $20 | $50		$10 | $25 | $45	
90-day supply Retail Pharmacy ** OR Mail Order Pharmacy	$10 | $40 | $100		$10 | $40 | $100		$20 | $40 | $75 Mail order only	NA

Above is a snapshot summary. Refer to the plan's Evidence of Coverage (EOC) for the full summary of coverage information.

[1] Incentives available to reduce individual deductible for inpatient care (max. $500) include: getting a biometric screening ($100 credit); receiving a flu shot ($100 credit); getting a non-smoking certification ($100 credit); getting a virtual second opinion ($100 credit); getting a condition care certification ($100 credit); participating in a diabetes prevention program ($100 credit); and getting a screening for anxiety or depression ($100 credit).

[2] Reduced to $10 if enrolled with personal doctor.

* Out-of-network services are based on a strictly limited schedule of allowances. Members must pay charges in excess of those scheduled amounts.

** Review your plan to ensure if Retail Pharmacy Maintenance Medications require a Home Delivery Opt-Out form to be completed to continue to have prescriptions filled at retail. Plans that do not require Home Delivery for Maintenance Medications may be subject to a higher copay after the 2nd fill.

DENTAL HMO COVERAGE

With a Dental HMO plan, the network is very limited, and you must choose a primary care dentist in the DeltaCare USA network. Your dentist will provide the care you need or refer you to a specialist. **Be sure that you are referred to a specialist in the HMO network.** If you have care with a provider that is not in the network, you will pay the entire bill as an HMO plan does not cover services out-of-network. For complete coverage details, please refer to the Summary Plan Description (SPD).

NOTE: The DeltaCare Dental plan is only available in California.

DELTA DENTAL®

Key Dental Benefits	DELTACARE DENTAL HMO
	In-Network Only
Deductible (per calendar year)	
Individual | Family	None
Calendar Year Benefit Maximum	
Per Member	Unlimited
Covered Services	
Diagnostic & Preventive	
Exams, X-rays, Cleanings, Sealants	$0 to $10 copay
Basic Services	
Fillings	No charge
Extractions	$0 - $40 copay
Root Canals	$20 - $60 copay
Major Services	
Bridges	$0 - $50 copay
Dentures	$65 - $125 copay
Crowns	$35 - $50 copay
Implants	Not covered
Orthodontia Services	
Child	$1,600 copay
Adult	$1,800 copay

DENTAL PPO COVERAGE

The Delta Dental PPO plan offers you the freedom and flexibility to use the dentist of your choice. However, you will maximize your benefits and reduce your out-of-pocket costs if you choose a dentist who participates in the Delta Dental network.

When choosing a dentist, you should note where the dentist falls within the network for Delta Dental. Review the following three types of dentists and how they work with Delta Dental.

PPO

Delta Dental refers to in-network preferred dentists as PPO providers. These providers have agreed to a contracted fee for covered services in your dental plan. If the provider normally charges more than that agreed upon fee, they cannot bill you for the difference.

PREMIER

These providers are considered out-of-network providers. However, they have also agreed to a contracted fee, but it is not as discounted as in-network providers. Premier providers also cannot charge you more than the agreed upon Premier contracted fee.

OUT-OF-NETWORK

These providers are out-of-network providers. They have not agreed to any contracted fee. When you have services with an out-of-network provider, you may be billed the difference from the usual, customary and reasonable (UCR) fee.

MAXIMIZE YOUR PLAN COVERAGE

Check the provider's in-network status

Always start with "Are you in the Delta Dental network?" when speaking to your provider. If your dentist says no, they would be considered out-of-network. If they tell you, "we take your insurance", that does not answer if they are in-network or out-of-network.

Get a pre-treatment estimate

If your dentist is recommending a treatment, ask your dentist to run the treatment against your dental insurance plan. They will receive an estimate back that will show what exactly is covered in your plan and the coverage cost for that treatment. This will protect you from a surprise bill and allow for you to make an informed decision.

Don't forget about the Flexible Spending Account (FSA)

If you can wait and you know how much you need to spend out-of-pocket for your dental treatment, you may want to consider putting funds aside in a Flexible Spending Account. See page 20 for more details on how to save on a pre-tax basis but also have those funds available on day 1 of the plan year.

INCENTIVE SCHEDULE

Your plan covers preventive and basic services at 100%. However, benefits under major services and for implants start at 70%. (Prosthodontics remain at 50% for the duration of the plan). If you visit the dentist one time during the year, the benefit will increase by 10% for the following year. This will occur each year until the benefit reaches 100%. If you do not visit the dentist during the year, your benefits will remain at the current level and will not decrease unless there is a lapse in coverage.

DENTAL PPO COVERAGE

NEW in 2027

Your dental PPO plan has been enhanced starting January 1, 2027!
The increased cost to make these improvements is 100% covered by the District.

- **Calendar Year Benefit Maximum increases**
  - ✓ The annual maximum benefit will increase from **$2,000 to $6,000**, providing significantly greater coverage before members become responsible for additional costs.
- **Removal of incentive progression steps in Diagnostic & Preventive and Basic Services**
  - ✓ Services are now covered at 100% starting the **first** year of dental enrollment.
- **Higher reimbursement levels for out-of-network dental services**
  - ✓ Delta Dental will now base covered procedure reimbursements on the typical costs charged in our **local region**, rather than a statewide average.
  - ✓ Because dental care costs in our area are generally higher than in many other parts of California, this enhancement will help ensure that plan reimbursements more closely reflect the actual cost of care, **reducing out-of-pocket expenses for members**.

DELTA DENTAL®

The following is a high-level overview of the coverage available. For complete coverage details, please refer to the plan summary.

Key Dental Benefits	DELTA DENTAL PPO		
	PPO In-Network	**Premier Out-of-Network**	**Non-Delta Dental Out-of-Network**
Calendar Year Deductible			
Individual | Family	$50 | $150	$50 | $150	$50 | $150
Calendar Year Benefit Maximum			
Per Member	$6,000 **Services with providers across all networks apply to a total $6,000 annual benefit per member.**	$6,000	$6,000
Implants – Separate Calendar Year Maximum Benefit	$2,000	$1,500	$1,500
Covered Services			
Diagnostic & Preventive Oral exams, cleanings, x-rays, fluoride treatment	Covered 100% deductible waived	Covered 100% of contracted fee deductible waived	Covered 100% of UCR deductible waived
Basic Services Fillings, extraction, root canals	Covered 100%	Covered 100% of contracted fee	Covered 100% of UCR
Major Services [1] Crowns, inlays, onlays, cast restorations	Covered 70% - 100%	Covered 70% - 100% of contracted fee	Covered 70% - 100% of UCR
Implants [1]	Covered 70% - 100%	Covered 70% - 100% of contracted fee	Covered 70% - 100% of UCR
Prosthodontics Bridges, dentures	Covered 50%	Covered 50% of contracted fee	Covered 50% of UCR
Orthodontia Benefit Adult and Child	Covered 50% up to $1,500 lifetime benefit	Covered 50% of contracted fee up to $1,500 lifetime benefit	Covered 50% of UCR up to $1,500 lifetime benefit

[1] Incentive schedule – see prior page for benefit explanation

VISION PPO COVERAGE

West Valley-Mission Community College District is pleased to offer you a vision plan with a comprehensive benefit through VSP. This is a PPO plan which gives you the freedom to find an eye care provider who's right for you. Choose a VSP doctor, a participating retail chain such as Costco, or any out-of-network provider. When accessing services from VSP in-network providers, you receive the most cost-effective benefits. There are cost savings and discounts on sunglasses, retinal screening and laser vision correction through a VSP doctor. When accessing services out-of-network, you will pay for the services out of your pocket and then file a claim for reimbursement up to a defined dollar limit.

vsp vision care

	VSP Plan	
	In-Network	**Out-of-Network Reimbursement**
Exam		
Routine	$25 copay	Up to $50 reimbursement
Lenses		
Single Vision	No charge after exam copay	Up to $50 reimbursement
Bifocal		Up to $75 reimbursement
Trifocal		Up to $100 reimbursement
Frames		
Frames	$150 allowance 20% off remaining balance	Up to $70 reimbursement
Featured Frame Brands	$170 allowance 20% off remaining balance	Up to $70 reimbursement
Costco	$80 allowance	n/a
Contact Lenses		
Contact Lenses – Elective	$150 allowance	Up to $105 reimbursement
Contact Lenses – Necessary	No charge	Up to $210 reimbursement

Accessing care is simple! If you do not already have a VSP contracted provider, you may search for one at www.vsp.com or by calling VSP at (800) 877-7195. When making the appointment, you will need to provide the following information:

- Your name and that you are a VSP member
- Your VSP member group or employer
- Your Social Security number or other identification number
- Your date of birth

If you are making an appointment for a dependent, provide the member's name, member's SSN and *dependent's* date of birth. Please note that you will not receive an ID card for the VSP coverage.

Frequency Schedule	
Exams	**Every 12 months**
Lenses	**Every 12 months**
Frames	**Every 24 months**
Contacts (in-lieu of lenses)	**Every 12 months**

DISTRICT PAID LIFE AND DISABILITY

BASIC LIFE AND AD&D

100% Employer Paid

Life insurance is an important benefit that is often overlooked. Because we are concerned with the well-being of you and your family, a Basic Life policy was purchased on your behalf to offset any expenses that are the result of your untimely death or injury. In the event of your death, this employer paid coverage, provided through MetLife, pays a benefit to the beneficiary(ies) you name. You are eligible for Basic Life Insurance in the amount of $50,000.

West Valley-Mission Community College District also provides you with the same benefit level of the company paid Basic Life policy for Basic Accidental Death and Dismemberment (AD&D) Insurance. AD&D Insurance provides your family with additional financial security if you die or suffer a severe injury such as loss of limb(s), sight, or permanent paralysis due to an accident. No more than the full amount will be paid for all losses resulting from the same accident.

Your Basic Life and AD&D benefit will reduce by 50% at age 70.

MetLife

$50,000
Life Insurance Benefit

Basic Life and AD&D example:
Should you lose your life as the result of an accident, AD&D coverage would pay an additional benefit equal to your Basic Life Insurance benefit.

Therefore, your beneficiary would receive $100,000.

DISABILITY COVERAGE

West Valley-Mission Community College District believes that long-term disability (LTD) coverage is important because anyone at any age may become injured or ill for an extended period of time. LTD coverage will replace 66 2/3% of your base salary to a monthly maximum of $5,000 if you are disabled for more than 90 days or at the end of accumulated sick leave, whichever is later, and are unable to work. LTD benefits are offset with other sources of income, such as Social Security and Workers' Compensation. Employees are automatically enrolled in LTD via PlanSource. To request a copy of the Certificate of Coverage, please contact the Human Resources Benefits Department. **Pre-existing condition exclusions apply.**

UNUM

100% Employer Paid

	Age at Disability	Maximum Benefit Period
Class 1	**Certificated employees with 5+ years of credited California service**	
	All Ages	1 year
Class 2	**All employees not eligible in another class**	
	< 60	To age 65 but not less than 5 years
	60 - 64	5 years
	65 - 69	To age 70 but not less than 1 year
	70+	1 year

VOLUNTARY LIFE AND AD&D

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. West Valley-Mission Community College District allows you the ability to purchase coverage for yourself and your dependents. Depending on the amount of voluntary life insurance you purchase, and who you are covering, you may be required to complete a Statement of Health (SOH). If you enroll in an amount that requires a SOH, MetLife may approve or decline your request for the amount of coverage that is subject to the Statement of Health. Reach out to Human Resources to obtain the application and SOH.

Open Enrollment Provisions

If you are already enrolled in employee voluntary life insurance and/or spouse voluntary life insurance, you may increase your coverage by one increment ($10,000) at open enrollment, up to the guarantee issue amount ($250,000 for employee, $20,000 for spouse) without completing a SOH. Amounts beyond this increment will need a SOH completed. Voluntary child life amounts may be changed without a SOH as long as the employee is also enrolled. You may change your voluntary AD&D election at open enrollment without a SOH.

Voluntary Life Insurance

How much can I elect?

Employee
Increments of $10,000 up to $500,000

NOTE: Must elect voluntary employee life to elect voluntary spouse or child life

Spouse
Increments of $10,000 up to the lesser of the employee's enrolled amount or $150,0000; **Coverage ends at age 70**

Child
Increments of $2,000 up to $10,000

When is Statement of Health Required?

Newly Hired
- Amounts over $250,000 for employee life and $20,000 for spouse life
- All amounts for children are approved once employee amount is approved

Existing Active Employee
- Not currently participating: all amounts
- Currently participating: amounts over open enrollment provision
- All amounts for children are approved once employee amount is approved

Employee and Spouse Voluntary Monthly Rates Per $10,000 of Coverage age banded rate changes take effect on the first of the month following or coinciding with birth date										Child(ren)
Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+	Per $2,000
$0.50	$0.60	$0.80	$1.00	$1.30	$1.90	$3.10	$5.50	$7.40	$13.90	$22.50	$0.20

Voluntary Accidental Death & Dismemberment Insurance (AD&D)

AD&D insurance provides protection to you or your beneficiaries in the case of an accidental death or serious injury. AD&D does not cover a death resulting from illness or natural causes. You may enroll at the employee only level or at a family level. Coverage is in increments of $50,000 up to a maximum of $250,000. If you enroll at the family level, the benefit amount is a percentage of your elected amount, as follows:

Employee Only: 100% of elected amount
Employee + Spouse: The spouse benefit is 50% of the employee amount
Employee + Child(ren): The child(ren) benefit is 15% of the employee amount
Employee + Family (Spouse & Child(ren): The spouse benefit is 40% of the employee amount and the child benefit is 10% of the employee amount

Voluntary AD&D Monthly Rates Per $50,000	
Employee	Family
$0.95	$1.30

FLEXIBLE SPENDING ACCOUNTS (FSA)

Flexible Spending Accounts (FSAs) are a tax-saving way to pay health care and dependent care expenses that you would typically pay out-of-pocket(e.g., deductibles, copays, day care expenses). The FSAs let you pay these expenses with pre-tax dollars. Each year that you would like to participate in the FSAs, you must elect the amount you want to contribute to either or both of the FSAs. Your contributions will be deducted from your paychecks in equal installments throughout the year and deposited into your account(s).. You may contribute up to calendar year maximums indicated below. Both accounts function separately. When you have eligible expenses, you submit a claim for reimbursement from your FSAs.

Annual Maximum Contribution

Health Care FSA	Dependent Care FSA
$3,400	**$7,500 per household** ($3,750 if married and file taxes separately)

Eligible Expenses

Health Care FSA

You can use this account for qualified medical, dental and vision expenses for yourself, your spouse or your dependent children. Some qualified expenses include:

- Coinsurance
- Copayments
- Deductibles
- Orthodontia
- Eye exams/eyeglasses
- LASIK eye surgery
- Arches/orthotic inserts
- First aid supplies
- Prescription sunglasses

Dependent Care FSA

You can use this account for expenses for services that allow you and your spouse (if you are married) to work or attend school full time. These services generally include day care, most day camps, and caregivers for dependent children under age 13. Another eligible expense is care of a household member who is physically or mentally incapable of caring for him/herself and qualifies as your federal tax dependent.

Over-the-counter Eligible Expenses

FSA accounts just got even more flexible and over-the-counter (OTC) items are now FSA-eligible!

OTC medicine such as pain relief and allergy pills no longer require a note of medical necessity or prescription from a physician. Menstrual products including tampons, pads, liners, sponges, and cups also do not require additional documentation to qualify for reimbursement.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Why Enroll?

- By putting money aside pre-tax, this lowers your taxable income – which in turn may increase your spendable income!
- Funds can be used for planned and unplanned eligible health care expenses. You don't need to earmark funds for a specific purpose.

Your Plan is Easier to Use With a Benefits Card!

When you enroll, you will be issued a Debit MasterCard to use for eligible expenses.

- The Debit MasterCard will debit your Health FSA when used to pay for eligible expenses at participating retailers. This eliminates you having to pay out-of-pocket for qualified expenses.
- Please note that you may be asked to substantiate claims per IRS Guidelines – SAVE ALL RECEIPTS so they can be submitted if requested.

Important Rules to Keep in Mind

FSAs offer sizeable tax advantages. The trade-off is that these accounts are subject to strict IRS regulations, including the following:

- The IRS has a strict "use it or lose it rule": If you do not use the full amount in your FSAs by the end of the grace period, you will lose any remaining funds.
- All claims must be submitted within 90 days of the end of the plan year.
- In the event of employment termination or unpaid leave, contributions to our plan stop and you can no longer incur expenses for reimbursement. Claims must be submitted within 90 days of termination date or first day of unpaid leave for expenses incurred prior to the loss of eligibility under the plan.
- Once you enroll in the FSAs, you cannot change your contribution amount during the year unless you experience a qualified status change.
- You cannot transfer funds from one FSA to another.

Grace Period

Our plan has a two-and-a-half-month grace period to allow you additional time to incur claims and use your contributed FSA funds to pay for eligible expenses. All services must be incurred between January 1, 2027 through March 15, 2028. You must submit for reimbursement no later than March 31, 2028.

Navigate to plansource.wealthcareportal.com to manage your FSA account, obtain account balances, download forms and review claims.

COMMUTER PLAN

The Commuter FSA is another method allowed to use pre-tax dollars for your daily commuting expenses, including transit and parking. This could save you as much as 30% on transit and parking – which adds up to a very powerful benefit and a substantial take-home bonus to your paycheck.

How does it work?

Participating in a commuter account is easy:

1. Choose the amount you would like to have deducted from your paycheck each pay period. **You can do this during open enrollment or at any time during the year.**
2. Use your PlanSource Benefit Mastercard to pay for eligible commuting costs.

Did you know?

Commuter benefits are flexible to meet your needs:

- You can always change your contribution amount if your commuting expenses change
- You can opt out of contributing at any time
- Funds left in your account at the end of the year can usually be rolled over and used the following year

How much can I elect?

The IRS defines the monthly maximum you can elect to put aside funds on a pre-tax basis. The amount is subject to change annually. The current monthly maximums are below. Transit and parking are separate accounts from each other, and each has its own maximum.

- **Transit (public transportation/ridesharing): Up to $340 per month**
- **Parking: Up to $340 per month**

What can it be used for?

Eligible expenses include things like:

Public transportation

Bus, ferry, subway, and train tickets or passes

Parking

Costs to park near your workplace or where you catch public transit

Ridesharing

Vanpool fees when there are six or more adult passengers

Important information regarding the Parking Benefit:

The following parking situations are NOT eligible under this benefit: Temporary work locations, parking fee for a conference or meeting, a one-day parking fee.

If you carpool and park, only the prime member (person with assigned parking spot) is entitled to the Parking Benefit.

RETIREMENT SAVINGS

It is never too early to plan for your retirement and West Valley-Mission Community College District offers you options to help you reach your goals. You may enroll in the 403(b) and/or 457 plans at any time throughout the year. Both are voluntary retirement savings accounts where you may put away money on a tax-advantaged basis. Please note that the annual limits for the 403(b) and 457 are subject to change annually.

Participant UNDER age 50	403(b)	457	Total
2026 annual limits	$24,500	$24,500	$49,000
Participant aged 50 and OVER	**403(b)**	**457**	**Total**
2026 annual limits	$32,500	$32,500	$65,000

ENROLLMENT INSTRUCTIONS

403(b) Steps to Enroll

1. Go to www.altamontclair.org/vendors and in the drop-down menu select *West Valley Mission Community College District* as your employer.
2. A list of vendors who offer 403(b) plans for WVMCCD will populate. This chart will tell you if the vendor offers a pre-tax plan and/or a Roth plan.
3. Select a vendor from the options available and set up a 403(b) account. You can find more data at www.403bcompare.com if you want to further compare the vendors.
4. You may set up your account directly with the vendor or you may enroll through a financial planner or tax consultant.
5. Go to the Payroll section of the District webpage and click on the Forms tab.
6. Complete the 403(b) Before Tax or 403(b) Roth After Tax Salary Reduction/Deduction Authorization and Amendment Form.
7. Return your completed form to the Payroll Department.

Alta Montclair 457 Steps to Enroll

1. Go to www.altamontclair.org/vendors and in the drop-down menu select *West Valley Mission Community College District* as your employer.
2. A list of vendors who offer 457 plans for WVMCCD will populate. Please note that you must scroll down past the 403(b) vendors to find the 457 vendors. This chart will tell you if the vendor offers a pre-tax plan and/or a Roth plan.
3. Select a vendor from the options available and set up a 457 account.
4. You may set up your account directly with the vendor or you may enroll through a financial planner or tax consultant.
5. Go to the Payroll section of the District webpage and click on the Forms tab.
6. Complete the EBS 457 Form and return to Payroll.

CalPERS Voya 457 Steps to Enroll

1. Review information about the CalPERS Voya 457 plan by visiting calpers.voya.com.
2. Go to the Payroll section of the District webpage and click on the Forms tab.
3. Complete and return the 457 Plan Enrollment Form and return it to the Payroll Department.

EMPLOYEE ASSISTANCE PROGRAM

Because unresolved personal issues can affect every aspect of one's life, including work performance, West Valley-Mission Community College District automatically provides you and your family with an Employee Assistance Program (EAP) at no cost to you. Call the EAP at (800) 834-3773 for confidential assistance with nearly any personal matter you may be experiencing. Licensed counselors are available 24 hours a day, 7 days a week, and can provide you with access to face-to-face counseling (up to three sessions per person per event), legal advice, financial consultation, medical advice, dependent care referrals and other community referrals.

CLAREMONT Powered by uprisehealth (800) 834-3773

Counseling Services

- Depression and stress
- Co-worker conflicts
- Grief and loss
- Marital or family issues
- Alcohol/Substance abuse issues

Dependent Care Referral

- Referrals to child or elder care providers
- Referrals to home health care providers
- Tips on interviewing and monitoring caregivers
- Relocation and adoption information
- Child/Summer day camp

Financial Consultation

- One 30-60 minute consultation per issue
- One credit report per intake year
- Budgeting
- Retirement planning
- Debt consolidation
- Financial Planning

Legal Consultation

- Simple Will kit
- Divorce and custody
- Small claims or personal injury
- Drunk driving offenses
- Criminal offenses
- Adoption Assistance information

Request Help

If your need is urgent, call 800-834-3773. Counselors are available at all times.

Popular Pages

EAP Orientation Videos
Employees & Families
Managers & HR
Newsletters
Virtual Brown Bags

EAP Benefits Center

Learn about your free and confidential services provided by Claremont EAP.

CREDIT UNION

As an employee of West Valley-Mission Community College District, you have access to Mirastar Federal Credit Union (formerly Santa Clara County FCU).

Through this establishment, you have access to free/discounted checking accounts, auto and mortgage loans, credit cards, financial workshops and much more.

For more information see the website and phone information on page 31.

- Competitive loans when you need them.
- FREE financial education and counseling.
- Online and Mobile banking available 24 hours.
- Youth Programs available to help your kids save and learn.
- Multiple branch and ATM locations.
- Scholarships awarded annually to student members.
- Great rates on mortgage and home equity loans.
- Access to discounted sporting events, concerts and more!
- FREE access to car buying services for you to find your dream car.
- Refer an eligible member and get $25.*

*Eligibility and terms apply.

IMPORTANT NOTICES

It is important that you review the list of notices below. Where required by law, full versions of the summary notices below along with other plan documents can be found by logging into the District's Benefits page at www.wvm.edu/benefits. If you are unable to access these for any reason, contact Human Resources for a printed copy.

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.

HIPAA – SPECIAL ENROLLMENT RIGHTS

This notice describes a group health plan's special enrollment rules including the right to special enroll within 30 days of the loss of other coverage or of marriage, birth of a child, adoption, or placement of a child for adoption, or within 60 days of a determination of eligibility for a premium assistance subsidy under Medicaid or CHIP.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT NOTICE (CHIPRA)

This annual notice notifies employees of potential state opportunities for premium assistance to help pay for employer- sponsored health coverage.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE (WHCRA)

Participants and beneficiaries of group health plans who are receiving mastectomy-related benefits can choose to have breast reconstruction following a mastectomy.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

MEDICARE PART D: PRESCRIPTION DRUG COVERAGE AND MEDICARE

Entities that offer prescription drug coverage on a group basis to active and retired employees and to Medicare Part D eligible individuals – must provide, or arrange to provide, a notice of creditable or non-creditable prescription drug coverage to Medicare Part D eligible individuals who are covered by, or who apply for, prescription drug coverage under the entity's plan. This creditable coverage notice alerts the individuals as to whether or not their prescription drug coverage is at least as good as the Medicare Part D coverage.

HIPAA WELLNESS PROGRAM NOTICE

This is a wellness program notice that is subject to HIPAA's notice requirement regarding reasonable alternative standards to earn a program incentive.

IMPORTANT NOTICES

HEALTH CARE REFORM NOTICE: NOTICE OF EXCHANGE/MARKETPLACE

Employer must provide all employees with an Exchange Notice that includes a description of services provided by the Exchange. The notice must explain the premium tax credit available if a qualified health plan is purchased through the Exchange. The employee must also be informed that they may lose the employer contribution to any benefit plans offered by the employer if a health plan through the Exchange is elected.

COBRA – FIRST NOTICE OF COBRA RIGHTS

This notice advises covered employees, covered spouses, and covered dependents of the right to purchase a temporary extension of group health coverage when coverage is lost due to a qualifying event.

ADA WELLNESS PROGRAM NOTICE

To comply with ADA, wellness plans that collect health information or involve medical exams must provide a notice to employees that explains how the information will be used, collected and kept confidential.

GINA WELLNESS PROGRAM NOTICE

Employers are prohibited from requesting or requiring genetic information. By providing this notice, any receipt of genetic information generally will be deemed inadvertent and not a violation of the prohibition.

FAMILY AND MEDICAL LEAVE ACT NOTICE

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 specific family reasons listed in the full notice. An eligible employee who is a covered service member's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness.

GENERAL NOTICE OF USERRA RIGHTS

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 against past and present members of the uniformed services, and applicants to the uniformed services.

DISCLOSURE TO ENROLEES REGARDING 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 in the full notice for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy.

Medical Plans

The CalPERS **Health Plan Search by ZIP Code** tool can show you all the medical plans a provider is participating in. This is a good tool if you are interested in moving between medical plans without having to change providers. The search is based on the zip code you enter which can be your home address or your work address. You may also go to the specific insurance carrier to find a provider. Instructions are listed on this page for the HMO plans and the next page for the PPO plans.

All CalPERS Plans (no account required) – www.calpers.ca.gov

- Choose Active Members > Health Benefit > Plans & Rates
- On right-hand side, click on "Health Plan Search by ZIP Code" and choose "Public Agency/School"
- Click on "Yes" to include your doctor
- Enter your doctor's name
- If found, click on the button of your doctor and continue
- The next page will list all the HMO and PPO plans that your doctor participates in

Medical Plans

Health Maintenance Organizations (HMOs)

Anthem Blue Cross – www.anthem.com/ca/calpers

- On the upper left side of the page click on "Menu"
- On the center of the page click on "Find Care"
- Scroll down and click the link for the plan you would like (**Traditional HMO** or **PERS Select HMO**)
- Once at the next screen, you can then search based on doctor/facility type and location

Blue Shield of CA – www.blueshieldca.com/calpers

- On the upper middle of the page click on "Find a provider" and choose "**Non-Medicare**"
- On the left of the page click on "**Access+ HMO Plan**" or "**Trio HMO Plan**"
- Once at the next screen you can then search based on doctor/facility type and location

Kaiser Permanente – www.kp.org/calpers

- Select "I'm considering joining Kaiser Permanente" or "I'm currently a Kaiser Permanente Member"
- On the lower right-hand side of the next page click on "Doctors & Locations"
- On the next screen select an area from the list of regions
- You can then search based on doctor name/type and location

Sutter Health – www.sutterhealthplan.org/find-provider

- Update your city, address or zip code and click "Search"
- Under filters, slide "Primary Care Provider" to the right to narrow down your search
- There are various other filters, such as medical group and city, to narrow your search further

FIND A PROVIDER

Medical Plans

Preferred Provider Organizations (PPOs)

Blue Shield – PERS Gold, PERS Platinum – https://includedhealth.com/microsite/calpers/
- Contact Included Health to assist you in reviewing if your provider is in the Blue Shield network (855) 633-4436
- Online provider lookup tool: log in through your Included Health account portal

Anthem Blue Cross – PORAC – www.porac.org
- On the home page click on "Insurance & Benefits Trust"
- On the next page scroll down and click on "Health Plans"
- Scroll to the bottom of the next page and click on "Find a Physician"
- Under the "Search as a Guest" section, select medical from the "What type of care you are searching for" drop down list and then search by "What state do you want to search with?"
- Next, select "Medical (Employer-Sponsored)" from the drop-down list of type of plan, and then select "**Blue Cross PPO (Prudent Buyer) – Large Group**" from the drop-down list of plan/network and click continue.
- You can then search based on location and physician type

Dental Plans

Preferred Provider Organization (PPO)

Delta Dental – www.deltadentalins.com
- On the left-hand side of the page complete the information under the "Find a Dentist" box
- Choose **Delta Dental PPO** under the "Select Network" drop down list and click "Find a Dentist"

Health Maintenance Organization (HMO)

DeltaCare USA – www.deltadentalins.com
- On the left-hand side of the page complete the information under the "Find a Dentist" box
- Choose **DeltaCare USA** under the "Select Network" drop down list and click "Find a Dentist"

Vision Plan

Preferred Provider Organization (PPO)

VSP – www.vsp.com
- On the left-hand side of the page click on "Find a Doctor" and search by location on the next screen
- Or call (800) 877-7195 and indicate that you are a VSP member

FREQUENTLY ASKED QUESTIONS

Q. Will there be a deduction taken from my paycheck for my benefit coverage?

The district provides a set annual contribution amount towards your benefits based on your medical coverage tier (Employee only, Employee +1, Employee+2 or more, Waive). The district contribution is applied towards your medical, dental and vision coverage. Please refer to the "Health Plan Options and Costs" sheet specific to your employee group for more detailed information. The basic life and accidental death and dismemberment benefit and long-term disability coverage are fully paid by the district. Voluntary plans (e.g., flexible spending accounts, life insurance, AD&D) are fully paid by the employee.

Q. What documentation will I need to submit to add a dependent?

In addition to their basic information:

- Child dependent – copy of birth certificate
- Spouse – copy of marriage certificate
- Domestic Partner – Affidavit of Domestic Partnership and a copy of the CA Declaration of Domestic Partnership filed with the Secretary of State

Q. How do I choose my medical and dental plans to ensure that I select the best plan(s)?

First review the informational materials in your benefits packet and on the district website to evaluate which plans would meet you/your family's current medical and dental needs. Some individuals prefer the convenience of having a co-payment and decide to choose an HMO plan. Others prefer to pay deductibles and coinsurance for the flexibility of going to participating and non-participating providers and therefore enroll in PPO plans. Regardless of which plans you choose, keep in mind that all of the plans, whether they are HMO or PPO, are designed to provide comprehensive health coverage to you and your family.

Q. How do I find participating providers who are on my plans?

Please refer to pages 28 and 29 of this Benefits Overview Guide.

Q. What are my benefit policy numbers, customer service numbers, and web addresses?

Please refer to page 31 of this Benefits Overview Guide.

Q. When will I receive my benefit identification cards?

Medical plan and Delta Care HMO identification cards will arrive in 2-3 weeks from the date that you complete your enrollments in Alight Worklife. **Delta Dental (PPO) and VSP – Cards are not issued by these carriers.** Please provide your health care practitioners with your social security and your group number.

Q. What if I'm not happy with the medical and/or dental plan? May I change my plans?

The opportunity to change your plans is offered during our open enrollment period which is held in the fall each year. Changes made during open enrollment will take effect January 1 of the following year.

Q. May I extend my benefit coverage if I leave the District?

Yes, you have the option to continue your health care coverage through COBRA. If you retire, you may be able to continue medical and dental coverage under the Educational Code provision. Details on these continuation options will be provided by the district, or, for some benefits, mailed to your home address by our COBRA Administrator, PlanSource. If you meet the eligibility criteria, you may also be able to port or convert your basic term life insurance, voluntary life insurance and/or convert your long-term disability policy.

CONTACT INFORMATION

Benefit	Carrier	Telephone	Address
WVMCCD Benefits Page	n/a	n/a	www.wvm.edu/benefits
CalPERS Medical	n/a	(888) 225-7377	www.calpers.ca.gov
Medical - HMO Group No: HTB050HT Traditional Group No: HNB050HS Select	Anthem	(855) 839-4524	www.anthem.com/ca/calpers
Medical - HMO Group No: W0051411 Access+ Group No: W0051411 Trio	Blue Shield	(800) 334-5847	www.blueshieldca.com/calpers
Medical - HMO Group No: 3	Kaiser	(800) 464-4000	www.kp.org/calpers
Medical - HMO Group No: TBD	Sutter Health	(833) 674-2334	www.sutterhealthplan.org/calpers
Medical - PPO Group No: W0051411 PERS Gold Group No: W0051411 PERS Platinum	Included Health (in partnership with Blue Shield)	(855) 633-4436	www.includedhealth.com/calpers
Medical - PORAC Group No: 1875JD	Anthem	(800) 288-6928	http://ibtofporac.org
Prescription Drugs	CVS Caremark	(833) 291-3649	www.caremark.com/calpers
Dental - PPO Group No: 07128	Delta Dental	(866) 499-3001	www.deltadentalins.com
Dental - HMO Group No: 71691	DeltaCare	(800) 422-4237	www.deltadentalins.com
Vision Group No: 12075324	VSP	(800) 877-7195	www.vsp.com
Flexible Spending Accounts (FSA)	PlanSource	(888) 266-1732	https://plansource.wealthcareportal.com/Page/Home customersupport@plansourcesupport.com
Life and AD&D - Basic and Voluntary Group No: KM05589969	MetLife	(800) 438-6388	www.metlife.com
Long Term Disability (LTD) Group No: 366070	Unum	(800) 421-0344	www.unum.com
Employee Assistance Program (EAP)	Claremont EAP	(800) 834-3773	www.claremonteap.com
Retirement Pension - CalPERS	CalPERS	(888) 225-7377	www.calpers.ca.gov
Retirement Pension - CalSTRS	CalSTRS	(888) 394-2060	www.calstrs.com
Retirement Plan - 403(b) and 457	Alta Montclair (TPA)	(866) 474-1144	www.altamontclair.org
Retirement Plan - 457 CalPERS Voya	Voya Financial	(888) 713-8244	calpers.voya.com
Credit Union	Mirastar Federal Credit Union	(800) 282-6212	www.mirastarfcu.org/
Benefits Enrollment Online Portal	PlanSource	n/a	https://thesource.plansource.com/westvalleymissioncommunity/login

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Prepared by:

The information in this guide was taken from various summary plan descriptions and benefit information. This summary of benefits is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. Full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will prevail. Carrier contracts are the final benefit determinant. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Benefit Summary, contact Human Resources.