



# 2026 Medical Premium Contributions

|                                                                                                                                                                          | HEALTH NET<br>CANOPYCARE HMO |                  | KAISER<br>PERMANENTE HMO |                  | BLUE SHIELD OF CALIFORNIA |                  |             |                  |            |                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|------------------|--------------------------|------------------|---------------------------|------------------|-------------|------------------|------------|------------------|
|                                                                                                                                                                          |                              |                  |                          |                  | TRIO HMO                  |                  | ACCESS+ HMO |                  | PPO        |                  |
| BIWEEKLY 26 PAY PERIODS                                                                                                                                                  |                              |                  |                          |                  |                           |                  |             |                  |            |                  |
| BOARD MEMBERS<br>AND CLASS. ADMIN.                                                                                                                                       | You Pay                      | Employer<br>Pays | You Pay                  | Employer<br>Pays | You Pay                   | Employer<br>Pays | You Pay     | Employer<br>Pays | You Pay    | Employer<br>Pays |
| Employee Only                                                                                                                                                            | 0.00                         | 364.57           | 0.00                     | 447.52           | 31.61                     | 467.48           | 44.32       | 539.70           | 277.50     | 408.83           |
| Employee +1                                                                                                                                                              | 144.91                       | 581.47           | 154.72                   | 737.55           | 198.59                    | 796.83           | 232.46      | 932.81           | 654.62     | 675.92           |
| Employee +2 or more                                                                                                                                                      | 332.43                       | 694.25           | 427.88                   | 833.53           | 455.72                    | 951.65           | 533.53      | 1,114.19         | 1,110.77   | 769.02           |
| CLASSIFIED<br>EMPLOYEES                                                                                                                                                  | You Pay                      | Employer<br>Pays | You Pay                  | Employer<br>Pays | You Pay                   | Employer<br>Pays | You Pay     | Employer<br>Pays | You Pay    | Employer<br>Pays |
| Employee Only                                                                                                                                                            | 0.00                         | 364.57           | 0.00                     | 447.52           | 31.61                     | 467.48           | 37.84       | 546.18           | 271.36     | 414.97           |
| Employee +1                                                                                                                                                              | 174.77                       | 551.61           | 202.17                   | 690.10           | 239.51                    | 755.91           | 280.35      | 884.92           | 620.55     | 709.99           |
| Employee +2 or more                                                                                                                                                      | 375.05                       | 651.63           | 496.37                   | 765.04           | 514.11                    | 893.26           | 601.91      | 1,045.81         | 815.07     | 1,064.72         |
| BIWEEKLY 21 PAY PERIODS                                                                                                                                                  |                              |                  |                          |                  |                           |                  |             |                  |            |                  |
| CLASSIFIED<br>EMPLOYEES                                                                                                                                                  | You Pay                      | Employer<br>Pays | You Pay                  | Employer<br>Pays | You Pay                   | Employer<br>Pays | You Pay     | Employer<br>Pays | You Pay    | Employer<br>Pays |
| EMPLOYEE ONLY                                                                                                                                                            |                              |                  |                          |                  |                           |                  |             |                  |            |                  |
| Dec. 20 - May 22                                                                                                                                                         | \$0.00                       | \$530.28         | \$0.00                   | \$650.94         | \$45.98                   | \$679.97         | \$55.04     | \$794.44         | \$394.71   | \$603.59         |
| Aug. 1 - Dec. 18                                                                                                                                                         | \$0.00                       | \$364.57         | \$0.00                   | \$447.52         | \$31.61                   | \$467.48         | \$37.84     | \$546.18         | \$271.36   | \$414.97         |
| EMPLOYEE +1                                                                                                                                                              |                              |                  |                          |                  |                           |                  |             |                  |            |                  |
| Dec. 20 - May 22                                                                                                                                                         | \$254.21                     | \$802.34         | \$294.07                 | \$1,003.78       | \$348.38                  | \$1,099.51       | \$407.78    | \$1,287.16       | \$902.62   | \$1,032.71       |
| Aug. 1 - Dec. 18                                                                                                                                                         | \$174.77                     | \$551.61         | \$202.17                 | \$690.10         | \$239.51                  | \$755.91         | \$280.35    | \$884.92         | \$620.55   | \$709.99         |
| EMPL. +2 OR MORE                                                                                                                                                         |                              |                  |                          |                  |                           |                  |             |                  |            |                  |
| Dec. 20 - May 22                                                                                                                                                         | \$545.43                     | \$947.83         | \$721.99                 | \$1,112.79       | \$747.80                  | \$1,299.29       | \$875.51    | \$1,521.18       | \$1,185.56 | \$1,548.68       |
| Aug. 1 - Dec. 18                                                                                                                                                         | \$375.05                     | \$651.63         | \$496.37                 | \$765.04         | \$514.11                  | \$893.26         | \$601.91    | \$1,045.81       | \$815.07   | \$1,064.72       |
| Classified School Term Only (STO) on 21 Pay Periods; January to June deductions (11 Pay Periods) include a 1.45 rate to pre-pay premiums for the summer coverage period. |                              |                  |                          |                  |                           |                  |             |                  |            |                  |
| MONTHLY 12 PAY PERIODS                                                                                                                                                   |                              |                  |                          |                  |                           |                  |             |                  |            |                  |
| ACADEMIC<br>ADMINS.                                                                                                                                                      | You Pay                      | Employer<br>Pays | You Pay                  | Employer<br>Pays | You Pay                   | Employer<br>Pays | You Pay     | Employer<br>Pays | You Pay    | Employer<br>Pays |
| Employee Only                                                                                                                                                            | \$0.00                       | \$789.90         | \$0.00                   | \$969.62         | \$68.51                   | \$1,012.85       | \$96.16     | \$1,169.21       | \$601.27   | \$885.76         |
| Employee +1                                                                                                                                                              | \$313.97                     | \$1,259.86       | \$335.22                 | \$1,598.04       | \$430.27                  | \$1,726.47       | \$503.69    | \$2,021.07       | \$1,418.63 | \$1,464.20       |
| Employee +2 or more                                                                                                                                                      | \$720.27                     | \$1,504.19       | \$927.04                 | \$1,806.02       | \$987.35                  | \$2,061.96       | \$1,155.99  | \$2,414.08       | \$2,406.65 | \$1,666.23       |
| FULL-TIME<br>FACULTY                                                                                                                                                     | You Pay                      | Employer<br>Pays | You Pay                  | Employer<br>Pays | You Pay                   | Employer<br>Pays | You Pay     | Employer<br>Pays | You Pay    | Employer<br>Pays |
| Employee Only                                                                                                                                                            | \$0.00                       | \$789.90         | \$0.00                   | \$969.62         | \$68.51                   | \$1,012.85       | \$96.16     | \$1,169.21       | \$601.27   | \$885.76         |
| Employee +1                                                                                                                                                              | \$293.19                     | \$1,280.64       | \$277.33                 | \$1,655.93       | \$401.80                  | \$1,754.94       | \$470.36    | \$2,054.40       | \$1,388.09 | \$1,494.74       |
| Employee +2 or more                                                                                                                                                      | \$667.34                     | \$1,557.12       | \$832.11                 | \$1,900.95       | \$914.79                  | \$2,134.52       | \$1,071.01  | \$2,499.06       | \$2,321.53 | \$1,751.35       |
| MONTHLY 9 PAY PERIODS                                                                                                                                                    |                              |                  |                          |                  |                           |                  |             |                  |            |                  |
| PART-TIME<br>FACULTY                                                                                                                                                     | You Pay                      | Employer<br>Pays | You Pay                  | Employer<br>Pays | You Pay                   | Employer<br>Pays | You Pay     | Employer<br>Pays | You Pay    | Employer<br>Pays |
| EMPLOYEE ONLY                                                                                                                                                            |                              |                  |                          |                  |                           |                  |             |                  |            |                  |
| Jan. 1 - May 31                                                                                                                                                          | \$0.00                       | \$1,263.84       | \$0.00                   | \$1,551.39       | \$109.62                  | \$1,620.56       | \$153.86    | \$1,870.74       | \$962.03   | \$1,417.22       |
| Sept. 1 - Dec. 31                                                                                                                                                        | \$0.00                       | \$789.90         | \$0.00                   | \$969.62         | \$68.51                   | \$1,012.85       | \$96.16     | \$1,169.21       | \$601.27   | \$885.76         |
| EMPLOYEE +1                                                                                                                                                              |                              |                  |                          |                  |                           |                  |             |                  |            |                  |
| Jan. 1 - May 31                                                                                                                                                          | \$469.10                     | \$2,049.02       | \$443.73                 | \$2,649.49       | \$642.88                  | \$2,807.90       | \$752.58    | \$3,287.04       | \$2,220.94 | \$2,391.58       |
| Sept. 1 - Dec. 31                                                                                                                                                        | \$293.19                     | \$1,280.64       | \$277.33                 | \$1,655.93       | \$401.80                  | \$1,754.94       | \$470.36    | \$2,054.40       | \$1,388.09 | \$1,494.74       |
| EMPL. +2 OR MORE                                                                                                                                                         |                              |                  |                          |                  |                           |                  |             |                  |            |                  |
| Jan. 1 - May 31                                                                                                                                                          | \$1,067.74                   | \$2,491.39       | \$1,331.38               | \$3,041.52       | \$1,463.66                | \$3,415.23       | \$1,713.62  | \$3,998.50       | \$3,714.45 | \$2,802.16       |
| Sept. 1 - Dec. 31                                                                                                                                                        | \$667.34                     | \$1,557.12       | \$832.11                 | \$1,900.95       | \$914.79                  | \$2,134.52       | \$1,071.01  | \$2,499.06       | \$2,321.53 | \$1,751.35       |

Part-time Faculty Employees January to May deductions (5 pay periods) include 1.60 rate to pre-pay premiums for the summer coverage period.



# Vision Plan Benefits-at-a-Glance

| Covered Services                                                                                                 |  | Vision Service Plan - Basic <sup>1</sup>                                                                                                                                                                                                    |  | Vision Service Plan - Premier                                                                                                                                                                                                               |  |                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------|--|
| Well Vision Exam                                                                                                 |  | \$10 co-pay every calendar year                                                                                                                                                                                                             |  | \$10 co-pay every calendar year                                                                                                                                                                                                             |  |                                                                                         |  |
| Single Vision Lenses                                                                                             |  | \$25 co-pay every other calendar year <sup>2</sup>                                                                                                                                                                                          |  | \$0 every calendar year                                                                                                                                                                                                                     |  |                                                                                         |  |
| Lined Bifocal Lenses                                                                                             |  | \$25 co-pay every other calendar year <sup>2</sup>                                                                                                                                                                                          |  | \$0 every calendar year                                                                                                                                                                                                                     |  |                                                                                         |  |
| Lined Trifocal Lenses                                                                                            |  | \$25 co-pay every other calendar year <sup>2</sup>                                                                                                                                                                                          |  | \$0 every calendar year                                                                                                                                                                                                                     |  |                                                                                         |  |
| Standard Progressive Lenses                                                                                      |  | 100% coverage every other calendar year                                                                                                                                                                                                     |  | 100% coverage every calendar year                                                                                                                                                                                                           |  |                                                                                         |  |
| Premium Progressive Lenses                                                                                       |  | \$95–\$105 co-pay every other calendar year                                                                                                                                                                                                 |  | \$25 co-pay every calendar year                                                                                                                                                                                                             |  |                                                                                         |  |
| Custom Progressive Lenses                                                                                        |  | \$150–\$175 co-pay every other calendar year                                                                                                                                                                                                |  | \$25 co-pay every calendar year                                                                                                                                                                                                             |  |                                                                                         |  |
| Standard Anti-Reflective Coating                                                                                 |  | \$41 co-pay every other calendar year                                                                                                                                                                                                       |  | \$25 co-pay every calendar year                                                                                                                                                                                                             |  |                                                                                         |  |
| Premium Anti-Reflective Coating                                                                                  |  | \$58–\$69 co-pay every other calendar year                                                                                                                                                                                                  |  | \$25 co-pay every calendar year                                                                                                                                                                                                             |  |                                                                                         |  |
| Custom Anti-Reflective Coating                                                                                   |  | \$85 co-pay every other calendar year                                                                                                                                                                                                       |  | \$25 co-pay every calendar year                                                                                                                                                                                                             |  |                                                                                         |  |
| Scratch-Resistant Coating                                                                                        |  | Fully covered every other calendar year                                                                                                                                                                                                     |  | Fully Covered every calendar year                                                                                                                                                                                                           |  |                                                                                         |  |
| Frames                                                                                                           |  | \$150 allowance for a wide selection of frames.<br>\$170 allowance for featured frames;<br>20% savings on amount over the allowance; \$80 allowance at Costco and Walmart/Sam's Club;<br>\$25 co-pay applies;<br>Every other calendar year. |  | \$300 allowance for a wide selection of frames.<br>\$320 allowance for featured frame;<br>20% savings on the amount over your allowance; \$165 allowance at Costco and Walmart/Sam's Club;<br>No additional co-pay;<br>Every calendar year. |  |                                                                                         |  |
| Contacts <i>(instead of glasses)</i>                                                                             |  | \$150 allowance every other calendar year <sup>2</sup>                                                                                                                                                                                      |  | \$250 allowance every calendar year                                                                                                                                                                                                         |  |                                                                                         |  |
| Contact Lens Exam                                                                                                |  | Up to \$60 co-pay every other calendar year <sup>2</sup>                                                                                                                                                                                    |  | Up to \$60 co-pay every calendar year                                                                                                                                                                                                       |  |                                                                                         |  |
| Essential Medical Eye Care<br><i>(for the treatment of urgent or acute ocular conditions)</i>                    |  | \$5 co-pay                                                                                                                                                                                                                                  |  | \$5 co-pay                                                                                                                                                                                                                                  |  |                                                                                         |  |
| Lightcare                                                                                                        |  | \$150 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue-light filtering glasses, instead of prescription glasses or contacts, every other calendar year.                                            |  | \$300 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue-light filtering glasses, instead of prescription glasses or contacts, every calendar year.                                                  |  |                                                                                         |  |
| Biweekly (26 Pay Periods)                                                                                        |  | 21 Pay Periods <sup>3</sup>                                                                                                                                                                                                                 |  | Monthly (12 Pay Periods)                                                                                                                                                                                                                    |  | 9 Pay Periods <sup>3</sup>                                                              |  |
| E Only \$5.48<br>E + 1 Dep. \$8.36<br>E + 2 or more \$17.09                                                      |  | E Only \$7.97   \$5.48<br>E+1 Dep. \$12.16   \$8.36<br>E+2 or more \$24.85   \$17.09                                                                                                                                                        |  | E Only \$11.87<br>E + 1 Dep. \$18.11<br>E + 2 or more \$37.02                                                                                                                                                                               |  | E Only \$18.99   \$11.87<br>E+1 Dep. \$28.98   \$18.11<br>E+2 or more \$59.23   \$37.02 |  |
| Your Coverage with Out-of-Network Providers                                                                      |  |                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                             |  |                                                                                         |  |
| Visit <a href="https://www.vsp.com">vsp.com</a> if you plan to see a provider other than a VSP network provider. |  |                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                             |  |                                                                                         |  |
| Exam Up to \$50<br>Frame Up to \$70                                                                              |  | Single Vision Lenses Up to \$45<br>Lined Bifocal Lenses Up to \$65                                                                                                                                                                          |  | Lined Trifocal Lenses Up to \$85<br>Progressive Lenses Up to \$85                                                                                                                                                                           |  | Contacts Up to \$105                                                                    |  |

<sup>1</sup>VSP Basic Plan coverage is included with your medical premium.

<sup>2</sup>Under the VSP Basic plan, new lenses may be covered the next year if Rx change is no less than a +/- 0.50 diopter power.

<sup>3</sup>Employees with 9 and 21 pay periods pay a pro-rated premium rate for VSP Premier before summer break.

In any instance where information in this chart conflicts with the plan's Evidence of Coverage (EOC), the plan's EOC shall prevail.



## Other Benefits Administered by City College of San Francisco (CCSF)

Delta Dental, Flexible Spending Accounts and other Voluntary Benefits are administered by the CCSF Benefits Unit. Please contact **CCSF Benefits Unit** at [benefits@ccsf.edu](mailto:benefits@ccsf.edu).

### Dental PPO

**City College of San Francisco (CCSF)** offers eligible employees the opportunity to enroll in dental benefits administered by Delta Dental. Enrollment in dental benefits is handled through the **CCSF Benefits Unit**. Visit [ccsf.edu](http://ccsf.edu) for details about covered services under this plan.

This PPO dental plan allows you to visit any in-network or out-of-network dentist. The plan pays higher benefits (and you pay less) when you visit an in-network PPO dentist.

Ask your Delta Dental dentist about costs before receiving services. You can request a pre-treatment estimate of costs before you receive care. For more information, call Delta Dental at **(888) 499-3001**.

### Flexible Spending Accounts (FSA)

FSAs can save you money by reducing your taxable income. You can enroll in a Healthcare FSA, a Dependent Care FSA, or both. Once enrolled, you set aside money pre-tax via payroll deduction to fund your FSA account(s). To receive FSA reimbursements, you must submit documentation to the plan administrator by required deadlines.

A Healthcare FSA helps to pay for qualifying medical expenses. Qualifying expenses include medical, pharmacy, dental and vision co-pays, acupuncture and chiropractic care and more.

Unused FSA Healthcare up to the maximum carryover fund amounts can carryover to the following year. Your carryover will be determined at the end of the claim filing period (March 31). Carryover funds can only be accessed for one plan year and any remaining carryover funds will be forfeited.

IRS Rules require FSA annual enrollment/election during Open Enrollment. For more information, read IRS code section 125, [irs.gov/forms](https://www.irs.gov/forms).

A Dependent Care FSA can help pay *pre-tax* for qualifying dependent care expenses. Qualifying expenses include certified day care, pre-school and elder care. Children in day care must be under age 13.

**FSA Dependent Care cannot be used for medical, dental or vision expenses for dependents.**

Unlike an FSA Healthcare, there is no carryover on FSA Dependent Care. FSA Dependent Care expenses and services need to be incurred in the same plan year or be forfeited. There are no exceptions.

Before enrolling in your FSA, work out a detailed estimate of the eligible expenses you are likely to incur. Budget conservatively. Please note, with an FSA your taxable income will be reduced for Social Security purposes so there may be a corresponding reduction in Social Security benefits.

Services and/or purchases must be made within the election year/eligibility period. Plan year is from January 1 to December 31. Funds are available after being deducted from your paycheck and received by *WageWorks*. There are no refunds for canceling or reducing elections.

FSA Healthcare and FSA Dependent Care expenses reimbursement claims must be submitted to *WageWorks* by March 31st for the prior plan year.

Per IRS rules, you forfeit all funds remaining in an FSA by end of the claim filing period unless covered by FSA Healthcare Carryover Provision.

For complete list of eligible healthcare and dependent care expenses and more information on FSA, visit [wageworks.com](http://wageworks.com).

### Commuter Benefits

**City College of San Francisco (CCSF)'s Benefits Unit** offers employees the opportunity to enroll in commuter benefits. This pre-tax benefit account can be used to pay for public transit (train, subway, bus, and ferry) and parking fees associated with work as part of your daily commute to and from work.

Save an average of up to 30% on public transit as part of your daily commute to and from work and reduce your overall tax burden (e.g. funds are withdrawn from your paycheck *before* taxes are deducted thereby reducing your taxable income). Sign up any time to start saving and there's no "use it or lose it" as long as you're enrolled. The commuter benefits account for CCSF employees are administered by *WageWorks*. Visit [wageworks.com](http://wageworks.com) for more information.

### Other Voluntary Benefits

Eligible **CCSF** employees may also purchase the voluntary benefits below:

- Individual life, accident, short-term disability, cancer/specified disease, hospital confinement indemnity, specified health event, dental and vision insurance.
- For more information about dental, FSA, and additional voluntary benefits that are administered through CCSF, visit [ccsf.edu](http://ccsf.edu).



# CCSF Provides Your Dental Benefits

For eligible employees, in this incentive plan, Delta Dental pays 70% of the contract allowance for covered diagnostic, preventive and basic services and 70% of the contract allowance for major services during the first year of eligibility. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that person visits the dentist at least once during the year. If an enrollee does not use the plan during the calendar year, the percentage remains at the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%. Group #15935.

|                                                                             |                                                                                                                                                |                        |                                                                  |                      |
|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|------------------------------------------------------------------|----------------------|
| Eligibility                                                                 | Enrolled eligible employee, spouse (includes domestic partner) and eligible dependent children to the end of the month dependent turns age 26. |                        |                                                                  |                      |
| Deductibles                                                                 | None                                                                                                                                           |                        |                                                                  |                      |
| Maximums                                                                    | Delta Dental PPO dentists: \$3,200 per person each calendar year.<br>Non-Delta Dental PPO dentists: \$3,000 per person each calendar year.     |                        |                                                                  |                      |
| D&P count towards maximum?                                                  | Yes.                                                                                                                                           |                        |                                                                  |                      |
| Waiting Period(s)                                                           | Basic Benefits<br>None                                                                                                                         | Major Benefits<br>None | Prosthodontics<br>None                                           | Orthodontics<br>None |
| Benefits and Covered Services*                                              | Delta Dental PPO dentists**                                                                                                                    |                        | Non-Delta Dental PPO dentists**                                  |                      |
| Diagnostic and Preventive Services (D&P)<br>Exams, (2) cleanings and x-rays | In-Network and Premier Dentist's contracted fee is covered at:<br><br>70%-100%                                                                 |                        | Reasonable and customary fee is only covered at:<br><br>70%-100% |                      |
| Basic Service<br>Fillings, posterior composites and sealants                |                                                                                                                                                |                        |                                                                  |                      |
| Endodontics (root canals)<br>Covered under Basic services                   |                                                                                                                                                |                        |                                                                  |                      |
| Periodontics (gum treatment)<br>Covered under Basic services                |                                                                                                                                                |                        |                                                                  |                      |
| Oral Surgery<br>Covered under Basic services                                |                                                                                                                                                |                        |                                                                  |                      |
| Major Services<br>Crowns, inlays, onlays and cast restorations              | 50%                                                                                                                                            |                        | 50%                                                              |                      |
| Prosthodontics<br>Bridges, dentures, and implants                           |                                                                                                                                                |                        |                                                                  |                      |
| Orthodontics Benefits<br>Adults and dependent children                      |                                                                                                                                                |                        |                                                                  |                      |
| Dental Accident Benefits<br>Adults and dependent children                   | 100%<br>(Separate \$1,000 maximum per person calendar year)                                                                                    |                        |                                                                  |                      |
| Orthodontics Maximums<br>Adults and dependent children                      | \$2,000 Lifetime                                                                                                                               |                        |                                                                  |                      |

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

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

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative (CCSF).