GCCCD & AFT Guild, Local 1931
Mid-term proposed changes to Faculty Collective Bargaining Agreement

September 17, 2020

The package proposal below would take effect January 1, 2021, pending ratification by the parties:

1. Changes to benefits plans, co-pays, and eligibility criteria (Article IX) as outlined in the attached document dated 9/17/20 "AFT Benefit Changes."

2. **The parties further agree to the following:**

   - For the Spring 2021 semester only, at the discretion of the instructor, ESL class maximums for Emergency Remote Teaching (ERT) designated classes only may be reduced to 18 students. All other instructors may petition their respective Dean to reduce the maximum for other classes taught in ERT format for Spring 2021 if a compelling argument can be made due to extraordinary circumstances. (Article 7.11.4.3.1)

   - Adjunct faculty members who are currently receiving District health benefits shall not have their benefits terminated during the Fall 2020 or Spring 2021 semesters, provided they can produce an affidavit stating they are not eligible to receive benefits from any other source (spouse, other employment, etc.). The District will use Fall 2021 and Spring 2020 semester assignments to determine eligibility for continued coverage. (Appendix B)

   - The District and the Guild will work together to create an interest free Computer Loan program, $2,000 per unit member, effective Fall 2021, with the loan re-paid in ten equal installments via payroll deduction. Eligible employees will include adjunct faculty with Priority of Assignment and tenured/tenure-track faculty. If the recipient of the loan separates from employment prior to repaying the entire amount of the loan, the remaining loan balance shall be deducted from the unit member's final pay warrant. (New provision)

   - Priority of Assignment (POA) for adjunct faculty will become effective as of the seventh semester of service, instead of the ninth. (Article 11.3)

   - The current pilot program for paid adjunct faculty office hours which was due to expire in June 2021 will be extended through the spring semester, 2023. If the state reduces or eliminates funding for this program prior to January 1, 2023, the parties agree to meet and negotiate over the terms and conditions of the paid adjunct faculty office hour program. (Article 11.10)

   - Adjunct faculty who have maintained six continuous years of service in Priority of Assignment status shall also be eligible to apply for a sabbatical. The overall number of available sabbatical leaves shall not be increased (per Section 14.3.1). Adjunct faculty who are approved for a sabbatical shall only have the option of a one semester leave. Compensation while on sabbatical shall be equal to their average assignment over the past two fall/spring or spring/fall semesters.

   - For the duration of the Agreement, the AFT and the District shall not be obligated to meet and negotiate with respect to any subject or matter with the exception of annual re-openers on Article IX, Compensation and Benefits, and those other Articles within this Agreement which specifically call for meeting and negotiating. Upon mutual written agreement, the parties may reopen additional articles for negotiations. (Article 22.3)

   - The expiration date of the collective bargaining agreement shall be extended for two years, expiring June 30, 2023. (Article 22.6)

3. **If Proposition 15 passes in November 2020, the parties agree to meet to negotiate the following proposal based upon the terms and conditions of the funding to be received by the District under Proposition 15:**

   - Lab assignments will be based on the formula of 15 hours/week = 1.0 LED. (Article 7.8.2)

For the Grossmont-Cuyamaca CCD:

Craig Leedham, Associate Vice-Chancellor
Human Resources, GCCCD

September 18, 2020
Date

For the AFT Guild, Local 1931:

Jim Mahler, President
AFT Guild, Local 1931

9/23/2020
Date

9/17/2020

Grossmont-Cuyamaca Community College District

AFT Benefit Changes

1. **Active Employees**
    a. District pays full cost for the following benefit plans:
        i. Kaiser HMO
        ii. UHC HMO Network 1
        iii. UHC Alliance $20/$30
        iv. UHC Alliance HRA $1200
        v. SIMNSA HMO (Cross Border Plan)

    b. Employees on UHC HMO Network 2 will pay monthly contributions for the difference between this plan rate and UHC Alliance $20/$30 rate. Employees will have the option to switch to a district fully paid plan. Monthly contributions for the UHC HMO Network 2 for calendar year 2021 are:
        i. Single = $235
        ii. Two Party = $489
        iii. Family = $694

    (Note: VEBA medical rates are not final until the District sends the signed renewal agreement to VEBA and VEBA delivers the final rates to the District – typically by mid-November.)

    c. The PPO plan shall be discontinued. Upon discontinuance of the PPO plan, continuity of care will be provided to employees by their new provider as specified in California Health and Safety Code § 1373.96 (attached to this document) and in individual Kaiser and UHC provider documents (attached as separate documents). The District will work with VEBA and affected members to provide one-on-one counseling sessions in order to determine which would be the best plan for the member to transition to.

    d. Active employees who can demonstrate coverage in a VEBA approved plan through their spouse or domestic partner can elect to opt-out of the District plan and will receive a stipend equal to 50% of the single premium for the Kaiser plan.
        i. The amount of the monthly stipend for calendar year 2021 is $336.50
        ii. Pending authorization from VEBA

2. <u>Retirees</u>

a. District pays full cost for Kaiser HMO and UHC HMO Network 1 plans for all retirees including the Out of State retirees.
    1. Retirees will pay the difference in premium between the plan they are on and Kaiser HMO premium
    2. No grandfathering for current employees

b. The PPO plan shall be discontinued for retirees. Upon discontinuance of the PPO plan, continuity of care will be provided to employees by their new provider as specified in California Health and Safety Code § 1373.96 (attached to this document) and in individual Kaiser and UHC provider documents (attached as separate documents). The District will work with VEBA and affected members to provide one-on-one counseling sessions in order to determine which would be the best plan for the member to transition to.

c. Retirees receiving District paid health coverage whose spouse is over age 65 shall be required to enroll their spouse in Medicare Part B.
    1. Still covered under the district's plan
    2. No grandfathering for current employees

d. Retirees who opt-out of coverage shall receive a stipend equal to 50% of the single premium for VEBA Kaiser plan.
    1. Grandfather current retirees.
    2. Pending authorization from VEBA

e. Raise retirement age for benefit eligibility to 55 for PERS (aligns with STRS) and increase the years of service to 15 years.
    1. Grandfather current retirees

f. Must retire from respective retirement system (STRS or PERS).
    1. Grandfather current retirees

g. All grandfathered retirees are subject to plan design and cost sharing changes.

3. Plan Design Changes

Kaiser HMO

Benefit	Current Kaiser HMO $10	Proposed Option Kaiser HMO $15
Deductible (Ind./Fam)	None	None
Medical Out-of-Pocket (Ind./Fam)	$1,500 / $3,000	$1,500 / $3,000
PCP Office Visit	$10 copay	$15 copay
Specialist Office Visit	$10 copay	$15 copay
Preventive Care	No charge	No charge
Inpatient Hospital Care	No charge	No charge
Mental Health Services (outpatient/inpatient)	$10 copay / No charge	$15 copay / No charge
Substance Abuse Services (outpatient/inpatient)	$10 copay / No charge	$15 copay / No charge
Diagnostic Laboratory Outpatient (standard)	No charge	No charge
Diagnostic and Complex Radiology (PET, MRI)	No charge	No charge
Outpatient Surgery	$10 copay	$15 copay
Outpatient Physical/Rehabilitation Therapy	$10 copay	$15 copay
Urgent Care (your medical group/other)	$10 copay	$15 copay
Emergency Room (copay waived if admitted)	$50 copay	$50 copay
Short-Term Prescription Drugs (generic/brand)	$10 copay up to a 30 day supply	$10 copay / $20 copay up to a 30 day supply
Maintenance Prescription Drugs (generic/preferred/non-preferred)	$10 copay up to a 100 day supply	$20 copay / $40 copay up to a 100 day supply

Chiropractor Service	$10 copay	$20 copay

UHC HMO Network 1

Benefit	Current UHC HMO 1 Plan A	Proposed Option UHC HMO 1 Plan D
Deductible (Ind./Fam)	None	None
Medical Out-of-Pocket (Ind./Fam)	$1,500 / $3,000	$1,500 / $3,000
Prescription Out-of-Pocket (Ind./Fam)	$3,000 / $6,000	$3,000 / $6,000
PCP Office Visit	$10 copay	$20 copay
Specialist Office Visit	$10 copay	$20 copay
Preventive Care	No charge	No charge
Inpatient Hospital Care	No charge	$250 copay per admit
Mental Health Services (outpatient/inpatient)	$10 copay / No charge	$20 copay / $250 copay per admit
Substance Abuse Services (outpatient/inpatient)	No charge	No charge
Diagnostic Laboratory Outpatient (standard)	No charge	No charge
Diagnostic and Complex Radiology (PET, MRI)	No charge	$100 copay
Outpatient Surgery	No charge	No charge
Outpatient Physical/Rehabilitation Therapy	$10 copay	$20 copay
Urgent Care (your medical group/other)	$10 copay / $50 copay	$20 copay / $75 copay

Emergency Room (copay waived if admitted)	$100 copay	$150 copay
Short-Term Prescription Drugs(generic/preferred/non-preferred)	$5 / $25 / 50%*Extra $5 at non EAN pharmacy	$10 / $25 / 50%*Extra $5 at non EAN pharmacy
Maintenance Prescription Drugs (generic/preferred/non-preferred)	$10 / $50 / 50%	$20 / $50 / 50%
Chiropractor Service	$10 copay	$20 copay
NETWORK	SHARP, RADY PRIMARY CARE ASSOCIATED MG, ARCH HEALTH PARTNERS MG, ENCOMPASS MG	SHARP, RADY PRIMARY CARE ASSOCIATED MG, ARCH HEALTH PARTNERS MG, ENCOMPASS MG

UHC HMO Network 2

Benefit	**Current UHC HMO 2 Plan A**	**Proposed Option UHC HMO 2 Plan D**
Deductible (Ind./Fam)	None	None
Medical Out-of-Pocket (Ind./Fam)	$3,000 / $6,000	$5,000 / $10,000
Prescription Out-of-Pocket (Ind./Fam)	$3,000 / $6,000	$3,000 / $6,000
PCP Office Visit	$20 copay	$30 copay
Specialist Office Visit	$20 copay	$40 copay
Preventive Care	No charge	No charge
Inpatient Hospital Care	No charge	$500 copay per admit
Mental Health Services (outpatient/inpatient)	$20 copay / No charge	$30 copay / $500 copay per admit
Substance Abuse Services (outpatient/inpatient)	No charge	No charge

Diagnostic Laboratory Outpatient (standard)	No charge	No charge
Diagnostic and Complex Radiology (PET, MRI)	No charge	$200 copay
Outpatient Surgery	No charge	$250 copay per admit
Outpatient Physical/Rehabilitation Therapy	$20 copay	$30 copay / $40 copay
Urgent Care (your medical group/other)	$20 copay / $50 copay	$30 copay / $100 copay
Emergency Room (copay waived if admitted)	$100 copay	$200 copay
Short-Term Prescription Drugs(generic/preferred/non-preferred)	$10 / $30 / 50%*Extra $5 at non EAN pharmacy	$15 / $35 / 50%*Extra $5 at non EAN pharmacy
Maintenance Prescription Drugs (generic/preferred/non-preferred)	$20 / $60 / 50%	$30 / $70 / 50%
Chiropractor Service	$20 copay	$30 copay
NETWORK	MERCY PMG, GREATER TRI-CITIES IPA, MID-COUNTY PMG, MULTI-CULTUREAL PMG, SAN DIEGO PMG, RADY	MERCY PMG, GREATER TRI-CITIES IPA, MID-COUNTY PMG, MULTI-CULTUREAL PMG, SAN DIEGO PMG, RADY

- No proposed plan design changes for the UHC Alliance plans. Network for UHC Alliance Plans are Scripps, UCSD, and RADY.

4. <u>TIMELINE</u>

a. August 2020: Receive from VEBA plan designs and adjust plan accordingly
b. August/Sept. 2020: Negotiations to finalize benefit changes
c. September 2020: Notify impacted employees of the changes including retirees
d. October 2020: Open Enrollment begins
e. November 2020: VEBA Participation Agreement must be signed by all groups
f. January 2021: New plans in effect

CALIFORNIA HEALTH AND SAFETY CODE SECTION 1373.96.

Cite as: Cal. Health & Safety Code §1373.96.
(a)A health care service plan shall at the request of an enrollee, provide the completion of covered services as set forth in this section by a terminated provider or by a nonparticipating provider.

(b)(1)The completion of covered services shall be provided by a terminated provider to an enrollee who at the time of the contract's termination, was receiving services from that provider for one of the conditions described in subdivision (c).

(2)The completion of covered services shall be provided by a nonparticipating provider to a newly covered enrollee who, at the time his or her coverage became effective, was receiving services from that provider for one of the conditions described in subdivision (c).

(c)The health care service plan shall provide for the completion of covered services for the following conditions:

(1)An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

(2)A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health care service plan in consultation with the enrollee and the terminated provider or nonparticipating provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

(3)A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

(4)A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.

(5)The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

(6)Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.

(d)(1)The plan may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services beyond the contract termination date.

(2)Unless otherwise agreed by the terminated provider and the plan or by the individual provider and the provider group, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated provider. Neither the plan nor the provider group is required to continue the services of a terminated provider if the provider does not accept the payment rates provided for in this paragraph.

(e)(1)The plan may require a nonparticipating provider whose services are continued pursuant to this section for a newly covered enrollee to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the nonparticipating provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services.

(2)Unless otherwise agreed upon by the nonparticipating provider and the plan or by the nonparticipating provider and the provider group, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider. Neither the plan nor the provider group is required to continue the services of a nonparticipating provider if the provider does not accept the payment rates provided for in this paragraph.

(f)The amount of, and the requirement for payment of, copayments, deductibles, or other cost sharing components during the period of completion of covered services with a

terminated provider or a nonparticipating provider are the same as would be paid by the enrollee if receiving care from a provider currently contracting with or employed by the plan.

(g)If a plan delegates the responsibility of complying with this section to a provider group, the plan shall ensure that the requirements of this section are met.

(h)This section shall not require a plan to provide for completion of covered services by a provider whose contract with the plan or provider group has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Profession Code, or fraud or other criminal activity.

(i)This section shall not require a plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract. This section shall not apply to a newly covered enrollee covered under an individual subscriber agreement who is undergoing a course of treatment on the effective date of his or her coverage for a condition described in subdivision (c).

(j)This section shall not apply to a newly covered enrollee who is offered an out-of-network option or to a newly covered enrollee who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans.

(k)The provisions contained in this section are in addition to any other responsibilities of a health care service plan to provide continuity of care pursuant to this chapter. Nothing in this section shall preclude a plan from providing continuity of care beyond the requirements of this section.

(l)The following definitions apply for the purposes of this section:

(1)“Individual provider” means a person who is a licentiate, as defined in Section 805 of the Business and Professions Code, or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.

(2)“Nonparticipating provider” means a provider who is not contracted with a health care service plan.

(3)“Provider” shall have the same meaning as set forth in subdivision (i) of Section 1345.

(4)“Provider group” means a medical group, independent practice association, or any other similar organization.