2023 Medical Premium Contribution Rates (Biweekly)

EMPLOYEE ONLY	HEALTH NET CANOPYCARE HMO		BLUE SHIELD OF CA TRIO HMO		BLUE SHIELD OF CA ACCESS+ HMO		KAISER PERMANENTE HMO		BLUE SHIELD OF CA PPO	
CITY & COUNTY OF SF	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**
MEA Misc. Unrep. Managers Unrep. Employees Elected Officials MEA – Fire MEA – Police	**$355.51**	**$0**	**$360.35**	**$36.69**	**$360.35**	**$71.58**	**$343.21**	**$0**	**$360.35**	**$302.17**
MTA	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**
MEA MTA Unrep. Managers	**$355.51**	**$0**	**$360.35**	**$36.69**	**$360.35**	**$71.58**	**$343.21**	**$0**	**$360.35**	**$302.17**
SUPERIOR COURT	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**
MEA Unrep. Managers Court Duty Officer Courts Comm. Assoc.	**$0**	**$355.51**	**$0**	**$397.04**	**$0**	**$431.93**	**$0**	**$343.21**	**$0**	**$662.52**

EMPLOYEE +1	HEALTH NET CANOPYCARE HMO		BLUE SHIELD OF CA TRIO HMO		BLUE SHIELD OF CA ACCESS+ HMO		KAISER PERMANENTE HMO		BLUE SHIELD OF CA PPO	
CITY & COUNTY OF SF	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**
MEA Misc. Unrep. Managers Unrep. Employees Elected Officials MEA – Fire MEA – Police	**$355.51**	**$354.14**	**$360.35**	**$432.36**	**$360.35**	**$502.14**	**$343.21**	**$341.83**	**$360.35**	**$924.94**
MEA	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**
MEA MTA Unrep. Managers	**$355.51**	**$354.14**	**$360.35**	**$432.36**	**$360.35**	**$502.14**	**$343.21**	**$341.83**	**$360.35**	**$924.94**
SUPERIOR COURT	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**
MEA Unrep. Managers Court Duty Officer Courts Comm. Assoc.	**$0**	**$709.65**	**$0**	**$792.71**	**$0**	**$862.49**	**$0**	**$685.04**	**$0**	**$1,285.29**

EMPLOYEE +2 OR MORE	HEALTH NET CANOPYCARE HMO		BLUE SHIELD OF CA TRIO HMO		BLUE SHIELD OF CA ACCESS+ HMO		KAISER PERMANENTE HMO		BLUE SHIELD OF CA PPO	
CITY & COUNTY OF SF	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**
MEA Misc. Unrep. Managers Unrep. Employees Elected Officials MEA – Fire MEA – Police	**$0**	**$1,003.58**	**$0**	**$1,121.11**	**$0**	**$1,219.85**	**$0**	**$968.75**	**$0**	**$1,816.29**
MTA	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**
MEA MTA Unrep. Managers	**$0**	**$1,003.58**	**$0**	**$1,121.11**	**$0**	**$1,219.85**	**$0**	**$968.75**	**$0**	**$1,816.29**
SUPERIOR COURT	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**
MEA Unrep. Managers Court Duty Officer Courts Comm. Assoc.	**$0**	**$1,003.58**	**$0**	**$1,121.11**	**$0**	**$1,219.85**	**$0**	**$968.75**	**$0**	**$1,816.29**

HMO Plans Comparison Chart of In-Network Medical Groups and Hospitals

	BLUE SHIELD OF CALIFORNIA		HEALTH NET CANOPYCARE HMO
	ACCESS+ HMO	TRIO HMO	
Provider Medical Group/IPA			
Brown and Toland Medical Group	Yes	Yes	No
Dignity Physicians Medical Group	Yes (Dominican-Santa Cruz)	Yes (Dominican-Santa Cruz)	Yes (Dominican-Santa Cruz)
Hill Physicians Medical Group	Yes	Yes	Yes
John Muir Physician Network	Yes	Yes	Yes
MarinHealth	No	No	Yes
Meritage	Yes	Marin County Only	Yes
Santa Clara Physician Network (SCCIPA)	Yes	Yes	Yes
Sutter Palo Alto Medical Foundation Physicians	Yes	No	No
Hospitals			
Dignity Health Hospitals/Medical Centers (St. Mary's, St. Francis, Sequoia, Dominican)	Yes	Yes	Yes
El Camino Hospital	Yes	Yes	No
Good Samaritan Hospital	Yes	Santa Clara and LA Counties Only	Yes
San Jose Regional Medical Center	Yes	Yes	Yes
San Ramon Regional Medical Center	Yes	Yes	Yes
Santa Clara Valley Medical Center	Yes	Yes	No
Stanford Hospitals and Clinics	Yes	Yes	No
Sutter Alta Bates Summit Medical Center	Yes	Yes	No
Sutter Eden Medical Center	Yes	Yes	No
Sutter California Pacific Medical Center (CPMC)	Yes	Yes (only w/ Brown and Toland IPA)	No
UCSF Benioff Children's Hospital	Yes	Yes	Yes
UCSF Sonoma Valley Hospital	Yes	Yes	Yes
UCSF Medical Center	Yes	Yes	Yes
Washington Hospital	Yes	Yes	Yes
Zuckerberg San Francisco General Hospital	No	No	Yes

Disclaimer: The information contained in this IPA Comparison Chart is subject to change. For a complete list of the most current Provider Medical Groups and Hospitals available to you, please contact your health plan directly.

Vision Plans

Members and dependents enrolled in a medical plan are automatically enrolled in vision benefits.

Vision Plan Benefits

SFHSS members and dependents enrolled in medical coverage automatically receive vision coverage through VSP Vision Care. If you elect to enroll in the VSP Premier plan and you have dependents enrolled in SFHSS medical coverage, your covered dependents will also be enrolled in the VSP Premier Plan. You may go to a VSP in-network or out-of-network provider. In-network providers now include **Walmart Vision** and **Sam's Club**. Visit **www.vsp.com** for a complete list of network providers.

Accessing Your Vision Benefits

To receive services from an in-network provider, contact the provider and identify yourself as a VSP Vision Care member *before* your appointment. VSP Vision Care will provide benefit authorization directly to the provider. Services must be received prior to the benefit authorization expiration date.

If you receive services from a network provider *without* prior authorization or obtain services from an out-of-network provider (including Kaiser Permanente), you are responsible for payment in full to the provider. You may submit an itemized bill to VSP for partial reimbursement. Compare the costs of out-of-network services to in-network costs before choosing. Download claim forms at **www.vsp.com**.

Basic Vision Plan Limits and Exclusions

- One set of contacts or eyeglass lenses every other calendar year unless enrolled in the VSP Premier Plan. If examination reveals prescription change of 0.50 diopter or more after 12 months, replacement lenses are covered.
- Eligible dependent children are covered in full for polycarbonate prescription lenses.
- Cosmetic extras, including progressive, tinted or oversize lenses, cost more.

Expenses Not Covered by Plan

- Orthoptics (and any associated supplemental testing), plano (non-prescription) lenses or two pairs of glasses in lieu of a pair of bifocals.
- Replacement of lenses or frames furnished that are lost or broken (except at the contracted intervals).
- Medical or surgical eye treatment (except for limited Essential Medical Eye Care).
- Corrective vision treatments such as, but not limited to, LASIK and PRK laser surgery. You may be eligible for discounts from a VSP doctor.

VSP Basic and Premier Vision Plans

You now have a choice. As a new hire or during Open Enrollment, you can remain in the VSP Basic Plan or enroll in the VSP Premier Plan for enhanced benefits.

VSP Computer Visioncare Benefit

Some union contracts provide employer-paid computer vision benefits. Coverage includes an annual computer vision exam, $75 in-network retail frame allowance every 24 months and single vision, bifocal, and trifocal lenses. You can also add anti-reflective or UV coating at no additional cost.

VSP Lightcare

Both Basic and Premier plans now include VSP LightCare. Members can choose to use their regular frame allowance for ready-made non-prescription sunglasses or ready-made non-prescription blue light filtering glasses, every 12 months.

VSP Vision Care Member Extras

VSP Vision Care offers exclusive special offers and discounts and rebates on popular contact lenses. VSP also provides savings on **hearing aids** through **TruHearing®** for you, covered dependents and extended family including parents and grandparents.

Vision Plan Benefits-at-a-Glance

Covered Services	VSP Basic[1]	VSP Premier
Well Vision Exam	$10 co-pay every calendar year	$10 co-pay every calendar year
Single Vision Lenses **Lined Bifocal Lenses** **Lined Trifocal Lenses**	$25 co-pay every other calendar year[2] $25 co-pay every other calendar year[2] $25 co-pay every other calendar year[2]	$0 every calendar year $0 every calendar year $0 every calendar year
Standard Progressive Lenses **Premium Progressive Lenses** **Custom Progressive Lenses**	100% coverage every other calendar year $95–$105 co-pay every other calendar year $150–$175 co-pay every other calendar year	100% coverage every calendar year $25 co-pay every calendar year $25 co-pay every calendar year
Standard Anti-Reflective Coating **Premium Anti-Reflective Coating** **Custom Anti-Reflective Coating**	$41 co-pay every other calendar year $58–$69 co-pay every other calendar year $85 co-pay every other calendar year	$25 co-pay every calendar year $25 co-pay every 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 $170 allowance for featured frames $80 allowance use at Costco and Walmart/Sam's Club $25 co-pay applies; 20% savings on amount over the allowance; every other calendar year	$300 allowance for a wide selection of frames $320 allowance for featured frames $165 allowance use at Costco and Walmart/Sam's Club No additional co-pay; 20% savings on the amount over your allowance every calendar year
Contacts *(instead of glasses)*	$150 allowance every other calendar year[2]	$250 allowance every calendar year
Contact Lens Exam	Up to $60 co-pay every other calendar year[2]	Up to $60 co-pay every calendar year
Essential Medical Eye Care *(for the treatment of urgent or acute ocular conditions)*	$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. Anti-reflective and UV coatings fully covered.	$250 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. Anti-reflective and UV coatings fully covered.
Vision Care Premium Rates	**VSP Basic Plan**	**VSP Premier Contribution (Biweekly)**
	Included with your medical premium.	**Employee Only $5.34** **Employee + 1 Dependent $8.12** **Employee + Family $16.64**

Your Coverage with Out-of-Network Providers

Visit **vsp.com** if you plan to see a provider other than a VSP network provider.

Exam	Up to $50	**Single Vision Lenses**	Up to $45	**Lined Trifocal Lenses**	Up to $85	**Contacts**	Up to $105
Frame	Up to $70	**Lined Bifocal Lenses**	Up to $65	**Progressive Lenses**	Up to $85		

[1]VSP Basic Plan coverage is included with your medical premium.

[2]Under the VSP Basic plan, new lenses may be covered the next year if Rx change is more than .50 diopters.

IFPTE Local 21, SEIU 1021 and miscellaneous unrepresented employees are also eligible for VDT Computer VisionCare benefits. In any instance where information in this chart conflicts with the plan's Evidence of Coverage (EOC), the plan's EOC shall prevail.

Dental Plans

Dental benefits are a valuable and fundamental part of your overall good health.

PPO Dental Plans

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

SFHSS offers the following PPO dental plan:

- **Delta Dental PPO**

Save Money By Choosing Network PPO Dentists

Delta Dental PPO has two different networks. Ask your dentist if they are a Delta Dental PPO network or Premier network dentist (Premier network dentists may have higher co-pays). When you use Delta Dental's network dentists, you are only responsible to pay your cost-share for covered services (i.e. deductible and co-insurance, within applicable benefit maximums). Delta Dental's network dentists are not allowed to charge you more for covered services beyond the negotiated rates and fees (balance billing), and your applicable cost-share. If you believe a network provider has charged you more, please call Delta Dental using the telephone numbers indicated under **Key Contacts** on the back of this guide. If you want to know what you are

Get More Annual Cleanings for Chronic Conditions at No Extra Charge

Delta Dental PPO's ***SmileWay*** program features 100% coverage for one annual periodontal scaling and root planing procedure and four of the following (any combination) per calendar or contract year: teeth cleaning and/or periodontal maintenance services for members with specific chronic conditions. This coverage is exempt from your Calendar Year Maximum. To enroll, call Delta Dental PPO directly at **(888) 335-8227**.

DHMO Dental Plans

Similar to medical HMOs, Dental Health Maintenance Organization (DHMO) plans require that you receive all of your dental care from within a network of participating dental offices. These networks are generally smaller than dental PPO networks.

Before you elect a DHMO plan, make sure that the plan's network includes the dentist of your choice.

Under these plans, services are covered either at no cost or a fixed co-pay. Out-of-pocket costs for these plans are generally lower than PPO plans.

SFHSS offers the following DHMO plans:

- **DeltaCare USA DHMO**
- **UnitedHealthcare Dental DHMO**

k Comparison

	Delta Dental PPO	DeltaCare USA DHMO	UnitedHealthcare Dental DHMO
Can I receive service from any dentist?	emier Network Covered lta Dental dentists will cost ject to balance billing. also choose a dentist Premier Network Dental provider. You pay less when you choose an in-network provider.	No. All services must be received from your assigned contracted network dentist.	No. All services must be received by an in-network dentist.
Do I need a referral for specialty care?	No.	Yes.	Yes.
Will I pay a flat rate for most services?	No. You pay a percentage of allowed charges.	Yes.	Yes.
Do I need to live in the plan's service area to enroll?	No.	Yes. You must live in this plan's service area.	Yes. You must live in this plan's service area.

Dental Plan Benefits-at-a-Glance

	Delta Dental PPO			DeltaCare USA DHMO	UnitedHealthcare Dental DHMO
Choice of Dentist	You may choose any licensed dentist. You will receive a higher level of benefit and lower out-of-pocket costs with Delta Dental PPO or Premier network dentists.			DeltaCare USA **network only**	UHC Dental **network only**
Deductible	None			None	None
Plan Year Maximum	$2,500 per person, per calendar year, excluding orthodontia benefits, diagnostic and preventive services (i.e. cleanings, exams and/or x-rays).			None	None
Covered Services	**PPO Dentists**	**Premier Dentists**	**Out-of-Network**	**In-Network Only**	**In-Network Only**
Cleanings[1] and Exams	100% covered annual - 2x/yr.; pregnancy - 3x/yr.	100% covered annual - 2x/yr.; pregnancy - 3x/yr.	80% covered annual - 2x/yr.; pregnancy - 3x/yr.	100% covered 1 every 6 months	100% covered 1 every 6 months
X-rays	100% covered full mouth 1x/5 years; bitewing 2x/year to age 18; 1x/year over age 18	100% covered full mouth 1x/5 years; bitewing 2x/year to age 18; 1x/year over age 18	80% covered full mouth 1x/5 years; bitewing 2x/year to age 18; 1x/year over age 18	100% covered some limitations apply	100% covered
Extractions	90% covered	80% covered	60% covered	100% covered	100% covered
Fillings	90% covered	80% covered	60% covered	100% covered limitations apply to resin materials	100% covered limitations apply
Crowns	90% covered	80% covered	50% covered	100% covered limitations apply to resin materials	100% covered limitations apply
Dentures, Pontics, and Bridges	50% covered	50% covered	50% covered	100% covered full and partial dentures 1x/5yrs.; fixed bridgework, limitations apply	100% covered full and partial dentures 1x/5yrs.; fixed bridgework, limitations apply
Endodontic/ Root Canals	90% covered	80% covered	60% covered	100% covered excluding the final restoration	100% covered
Oral Surgery	90% covered	80% covered	60% covered	100% covered authorization required	100% covered
Implants	50% covered	50% covered	50% covered	Not covered	Covered Refer to co-pay schedule
Orthodontia	50% covered child $2,500 lifetime max; adult $2,500 lifetime max.	50% covered child $2,000 lifetime max; adult $2,000 lifetime max.	50% covered child $1,500 lifetime max; adult $1,500 lifetime max.	Employee pays: $1,600/child $1,800/adult $350 startup fee; limitations apply	Employee pays: $1,250/child $1,250/adult $350 startup fee; limitations apply
Night Guards	80% covered (1x3yr.)	80% covered (1x3yr.)	80% covered (1x3yr.)	$100 co-pay	100% covered

[1]Members with chronic conditions (diabetes, heart disease, HIV/AIDS, rheumatoid arthritis and stroke) may receive up to 4 cleanings per year, through the ***SmileWay*** program (Calendar Year Benefit Maximum does not apply). In any instance where information in this chart conflicts with a plan's Evidence of Coverage (EOC), the plan's EOC shall prevail.

Dental Premium Contribution Rates (Biweekly)

	DELTA DENTAL PPO		DELTACARE USA DHMO		UNITEDHEALTHCARE DENTAL DHMO	
CCSF & MTA MEA	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**
Employee Only	$23.93	$2.31	$12.22	$0	$11.53	$0
Employee +1 Dependent	$50.49	$4.62	$20.16	$0	$19.05	$0
Employee +2 or More Dependents	$71.80	$6.92	$29.82	$0	$28.16	$0

SUPERIOR COURT MEA	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**
Employee Only	$26.24	$0	$12.22	$0	$11.53	$0
Employee +1 Dependent	$55.11	$0	$20.16	$0	$19.05	$0
Employee +2 or More Dependents	$78.72	$0	$29.82	$0	$28.16	$0