Medical Premium Contribution Rates (Biweekly)

2022 Medical Premium Contribution Rates: Employee Only (Biweekly)

	HEALTH NET CANOPYCARE HMO		BLUE SHIELD OF CALIFORNIA TRIO HMO		BLUE SHIELD OF CALIFORNIA ACCESS+ HMO		KAISER PERMANENTE HMO		BLUE SHIELD OF CA PPO-ACCOLADE	
	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay
Sup. Ct. Employees Loc. 21	$396.47	$0.00	$377.03	$0.00	$429.89	$0.00	$330.45	$0.00	$617.16	$0.00
Sup. Ct. Employees Loc. 1021										
Sup. Ct. Judges										
Sup. Ct. Reporters										
Sup. Ct. Staff Attys.										
Sup. Ct. Staff Attys. Cashback[1]										
Sup. Ct. Interpreters										
Sup. Ct. Unrep. Prof.										

2022 Medical Premium Contribution Rates: Employee +1 (Biweekly)

	HEALTH NET CANOPYCARE HMO		BLUE SHIELD OF CALIFORNIA TRIO HMO		BLUE SHIELD OF CALIFORNIA ACCESS+ HMO		KAISER PERMANENTE HMO		BLUE SHIELD OF CA PPO-ACCOLADE	
	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay
Sup. Ct. Employees Loc. 21	$791.57	$0.00	$752.68	$0.00	$858.42	$0.00	$659.52	$0.00	$1,193.75	$0.00
Sup. Ct. Employees Loc. 1021										
Sup. Ct. Judges										
Sup. Ct. Reporters										
Sup. Ct. Staff Attys.										
Sup. Ct. Staff Attys. Cashback[1]										
Sup. Ct. Interpreters										
Sup. Ct. Unrep. Prof.										

2022 Medical Premium Contribution Rates: Employee +2 or more (Biweekly)

	HEALTH NET CANOPYCARE HMO		BLUE SHIELD OF CALIFORNIA TRIO HMO		BLUE SHIELD OF CALIFORNIA ACCESS+ HMO		KAISER PERMANENTE HMO		BLUE SHIELD OF CA PPO-ACCOLADE	
	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay
Sup. Ct. Empl. Loc. 21	$1,119.49	$0.00	$1,064.47	$0.00			$932.64	$0.00	$1,299.00	$386.36
Sup. Ct. Empl. Loc. 1021										
Sup. Ct. Judges					$1,214.10	$0.00			$1,685.36	$0.00
Sup. Ct. Rep.									$1,299.00	$386.36
Sup. Ct. Staff Attys.										
Sup. Ct. Staff Attys. Cashback[1]					$1,202.08	$12.02			$1,202.08	$483.28
Sup. Ct. Interpreters					$1,214.10	$0.00			$1,299.00	$386.36
Sup. Ct. Unrep. Prof.										

[1]Attorneys with enrolled dependents who wish to elect the cash back rate must complete additional forms. Contact SFHSS for details.

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® $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 at Costco® 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
Primary Eye Care *(for the treatment of urgent or acute ocular conditions)*	$5 co-pay	$5 co-pay

Vision Care Discounts		
Laser Vision Correction	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities	Average 15% off regular price or 5% off promotional price; discounts only available from contracted facilities
Vision Care Premium Rates	**VSP Basic Plan**	**VSP Premier Contribution (Biweekly)**
	Included in your medical premium.	**Employee Only $4.85** **Employee + 1 Dependent $7.35** **Employee + Family $15.13**

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 Premium Contribution Rates (Biweekly)

	DELTA DENTAL PPO		DELTACARE USA DHMO		UNITEDHEALTHCARE DENTAL DHMO	
SUPERIOR COURT OF SAN FRANCISCO	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**	**Employer Pays**	**You Pay**
Employee Only	$22.77	$0	$12.22	$0	$11.53	$0
Employee + 1 Dependent	$47.81	$0	$20.16	$0	$19.05	$0
Employee + 2 or More Dependents	$68.30	$0	$29.82	$0	$28.16	$0