



Medical Premium Contribution Rates (Biweekly)

2023 Medical Premium Contribution Rates: Employee Only (Biweekly)

	HEALTH NET CANOPYCARE HMO		BLUE SHIELD OF CALIFORNIA TRIO HMO		ACCESS+ HMO		KAISER PERMANENTE HMO		BLUE SHIELD OF CA PPO	
	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										
Sup. Ct. Employees Loc. 1021										
Sup. Ct. Judges										
Sup. Ct. Reporters	\$355.51	\$0	\$397.04	\$0	\$431.93	\$0	\$343.21	\$0	\$662.52	\$0
Sup. Ct. Staff Attys.										
Sup. Ct. Staff Attys. Cashback ¹										
Sup. Ct. Interpreters										
Sup. Ct. Unrep. Prof.										

2023 Medical Premium Contribution Rates: Employee +1 (Biweekly)

	HEALTH NET CANOPYCARE HMO		BLUE SHIELD OF CALIFORNIA TRIO HMO		ACCESS+ HMO		KAISER PERMANENTE HMO		BLUE SHIELD OF CA PPO	
	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										
Sup. Ct. Employees Loc. 1021										
Sup. Ct. Judges										
Sup. Ct. Reporters	\$709.65	\$0	\$792.71	\$0	\$862.49	\$0	\$685.04	\$0	\$1,285.29	\$0
Sup. Ct. Staff Attys.										
Sup. Ct. Staff Attys. Cashback ¹									\$1,228.08	\$57.21
Sup. Ct. Interpreters									\$1,285.29	\$0
Sup. Ct. Unrep. Prof.										

2023 Medical Premium Contribution Rates: Employee +2 or more (Biweekly)

	HEALTH NET CANOPYCARE HMO		BLUE SHIELD OF CALIFORNIA TRIO HMO		ACCESS+ HMO		KAISER PERMANENTE HMO		BLUE SHIELD OF CA PPO	
	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									\$1,325.00	\$491.29
Sup. Ct. Empl. Loc. 1021									\$1,816.29	\$0
Sup. Ct. Judges										
Sup. Ct. Rep.	\$1,003.58	\$0	\$1,121.11	\$0	\$1,219.85	\$0	\$968.75	\$0	\$1,325.00	\$491.29
Sup. Ct. Staff Attys.										
Sup. Ct. Staff Attys. Cashback ¹									\$1,228.08	\$588.21
Sup. Ct. Interpreters									\$1,325.00	\$491.29
Sup. Ct. Unrep. Prof.										

¹Attorneys 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		\$25 co-pay every other calendar year ²		\$0 every calendar year			
Lined Bifocal Lenses		\$25 co-pay every other calendar year ²		\$0 every calendar year			
Lined Trifocal Lenses		\$25 co-pay every other calendar year ²		\$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 \$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 <i>(instead of glasses)</i>		\$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 <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. 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 in 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		

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

²Under 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	\$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

