2025 Medical Premium Contributions

	HEALTH NET CANOPYCARE HMO		KAISER PERMANENTE HMO		BLUE SHIELD OF CALIFORNIA					
					TRIO HMO		ACCESS+ HMO		PPO	
BIWEEKLY 26 PAY PERIODS										
BOARD MEMBERS AND CLASS. ADMIN.	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays
Employee Only	0.00	365.27	0.00	406.79	28.93	427.87	40.77	496.42	275.91	406.48
Employee +1	145.37	583.33	140.76	670.99	181.90	729.85	213.96	858.58	651.23	672.42
Employee +2 or more	333.62	696.72	389.36	758.49	417.51	871.85	491.17	1,025.72	1,105.22	765.18
CLASSIFIED EMPLOYEES	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays
Employee Only	0.00	365.27	0.00	406.79	28.93	427.87	34.81	502.38	269.81	412.58
Employee +1	175.33	553.37	183.93	627.82	219.38	692.37	258.04	814.50	617.34	706.31
Employee +2 or more	376.39	653.95	451.68	696.17	471.00	818.36	554.12	962.77	811.00	1,059.40
BIWEEKLY 21 PAY PERIODS										
CLASSIFIED EMPLOYEES	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays
EMPLOYEE ONLY										
Dec. 21 - May 23	0.00	531.30	0.00	591.69	42.08	622.36	50.63	730.73	392.45	600.12
Aug. 2 - Dec. 19	0.00	365.27	0.00	406.79	28.93	427.87	34.81	502.38	269.81	412.58
EMPLOYEE +1										
Dec. 21 - May 23	255.03	804.90	267.53	913.19	319.10	1,007.08	375.33	1,184.73	897.95	1,027.36
Aug. 2 - Dec. 19	175.33	553.37	183.93	627.82	219.38	692.37	258.04	814.50	617.34	706.31
EMPL. +2 OR MORE										
Dec. 21 - May 23	547.48	951.20	656.99	1,012.61	685.09	1,190.34	805.99	1,400.39	1,179.64	1,540.95
Aug. 2 - Dec. 19	376.39	653.95	451.68	696.17	471.00	818.36	554.12	962.77	811.00	1,059.40

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 ADMINS.	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays
Employee Only	0.00	791.41	0.00	881.38	62.70	927.02	88.45	1,075.46	597.82	880.68
Employee +1	314.97	1,263.88	304.97	1,453.81	394.11	1,581.36	463.61	1,860.23	1,411.29	1,456.62
Employee +2 or more	722.84	1,509.56	843.58	1,643.42	904.56	1,889.07	1,064.20	2,222.40	2,394.63	1,657.90
FULL-TIME FACULTY	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays
Employee Only	0.00	791.41	0.00	881.38	62.70	927.02	88.45	1,075.46	597.82	880.68
Employee +1	294.13	1,284.72	252.30	1,506.48	368.03	1,607.44	432.93	1,890.91	1,380.91	1,487.00
Employee +2 or more	669.72	1,562.68	757.19	1,729.81	838.09	1,955.54	985.97	2,300.63	2,309.93	1,742.60
MONTHLY 9 PAY PERIODS										
PART-TIME FACULTY	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays	You Pay	Employer Pays
EMPLOYEE ONLY										
Jan. 1 - May 31	0.00	1,266.26	0.00	1,410.21	100.32	1,483.23	141.52	1,720.74	956.51	1,409.09
Sept. 1 - Dec. 31	0.00	791.41	0.00	881.38	62.70	927.02	88.45	1,075.46	597.82	880.68
EMPLOYEE +1										
Jan. 1 - May 31	470.61	2,055.55	403.68	2,410.37	588.85	2,571.90	692.69	3,025.46	2,209.46	2,379.20
Sept. 1 - Dec. 31	294.13	1,284.72	252.30	1,506.48	368.03	1,607.44	432.93	1,890.91	1,380.91	1,487.00
EMPL. +2 OR MORE										
Jan. 1 - May 31	1,071.55	2,500.29	1,211.50	2,767.70	1,340.94	3,128.86	1,577.55	3,681.01	3,695.89	2,788.16
Sept. 1 - Dec. 31	669.72	1,562.68	757.19	1,729.81	838.09	1,955.54	985.97	2,300.63	2,309.93	1,742.60

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[1]	Vision Service Plan - 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; 20% savings on amount over the allowance; every other calendar year. $80 allowance use at Costco and Walmart/ Sam's Club. $25 co-pay applies.	$300 allowance for a wide selection of frames. $320 allowance for featured frame; 20% savings on the amount over your allowance every calendar year. $165 allowance use at Costco and Walmart/ Sam's Club. No additional co-pay.
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.	$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[3]	Monthly (12 Pay Periods)	9 Pay Periods[3]
E Only $5.48 **E + 1 Dep. $8.36** **E + 2 or more $17.09**	**E Only $7.97** | **$5.48** **E+1 Dep. $12.16** | **$8.36** **E+2 or more $24.85** | **$17.09**	**E Only $11.87** **E + 1 Dep. $18.11** **E + 2 or more $37.02**	**E Only $18.99** | **$11.87** **E+1 Dep. $28.98** | **$18.11** **E+2 or more $59.23** | **$37.02**

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

[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 no less than a +/- 0.50 diopter power.
[3]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.

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%.

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. **Non-Delta Dental PPO dentists:** $3,000 per person each calendar year.			
D&P count towards maximum?	Yes.			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None
Benefits and Covered Services*	**Delta Dental PPO dentists****		**Non-Delta Dental PPO dentists****	
Diagnostic and Preventive Services (D&P) Exams, (2) cleanings and x-rays	In-Network and Premier Dentist's contracted fee is covered at: 70%-100%		Reasonable and customary fee is only covered at: 70%-100%	
Basic Service Fillings, posterior composites and sealants				
Endodontics (root canals) Covered under Basic services				
Periodontics (gum treatment) Covered under Basic services				
Oral Surgery Covered under Basic services				
Major Services Crowns, inlays, onlays and cast restorations				
Prosthodontics Bridges, dentures, and implants	50%		50%	
Orthodontics Benefits Adults and dependent children				
Dental Accident Benefits Adults and dependent children	100% (Separate $1,000 maximum per person calendar year)			
Orthodontics Maximums 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).