SBCSS Health Plans Offered for 2024-2025

CSEA Employees Only

The monthly contribution is the same for employees only and family.

	Medical Plan Choices	10 - Pay Employee Monthly Cost	11- Pay Employee Monthly Cost	12 - Pay Employee Monthly Cost
Kaiser Permanente	**Kaiser - Plan #1 (Kaiser Plan 8)** *$20 co-payment / Pharmacy $10 Generic / $20 Brand* *100% hospital covered*	$ 133.79	$ 121.63	$ 111.49
	Kaiser - Plan #2 (Kaiser Plan 12) *$30 co-payment/ Pharmacy $15 Generic/ $30 Brand* *$250 co-payment for hospital admission*	$ 33.78	$ 30.71	$ 28.15
	Kaiser - Plan #3 HDHP (Kaiser Plan 1) $1,600 Single / $3,200 Family deductible Pharmacy $10/ $30 after deductible *$20 co-payment after reaching deductible*	$ 41.71	$ 37.92	$ 34.76
Blue Shield HMO	**Blue Shield TRIO ACO - Plan #1** **(Blue Shield HMO Trio C20)** *$20 co-payment /100% hospital covered*	$ 81.86	$ 74.42	$ 68.22
	Blue Shield Access Plus - Plan #2 **(Blue Shield HMO Access+ C20)** *$20 co-payment / $500 co-payment hospital*	$ 195.72	$ 177.93	$ 163.10
	Blue Shield TRIO ACO - Plan #7 **(Blue Shield HMO Trio 7)** *$30 co-payment / $500 co-payment hospital*	$ 0	$ 0	$ 0
	Blue Shield Access Plus - Plan #7 **(Blue Shield HMO Access+ 7)** *$30 co-payment / $500 co-payment hospital*	$ 154.86	$ 140.78	$ 129.05
Blue Shield PPO	**Blue Shield PPO - Plan #1** **(Blue Shield PPO Cust 20-500)** *$500 single/ $1,000 family* In-Network	$ 2,207.47	$ 2,006.79	$ 1,839.56
	Blue Shield PPO – Plan #1A Tandem **(Blue Shield PPO Tandem Cust 20-500)** $500 single/ $1,000 family In-Network	$ 2,169.43	$ 1,972.21	$ 1,807.86
	Blue Shield HDHP CSEBA Premier - Plan #2 **(Blue Shield Premier PPO Savings 1600)** $1,600 single / $3,200 family In-Network	$ 154.33	$ 140.30	$ 128.61
	Blue Shield HDHP CSEBA Tandem - #2A **(Blue Shield PPO Premier Tandem Savings 1600)** **S**1,600 single/ $3,200 family In-network	$ 71.84	$ 65.31	$ 59.87
	Non-Medical Plan Choices			
Dental (Delta Dental PPO)	**Dental Plan #1** Each enrolled family member: *$2,500 In-Network/$2,000 out-of-network*	$ 0	$0	$ 0
	Dental Plan #2 Each enrolled family member: *$2,000 In-Network/$1,500 out-of-network* ***with Ortho***	$ 0	$0	$ 0
Vision (EYEMED)	**Vision Plan #1** Each enrolled family member: $150 frames or contacts In-Network	$ 0	$0	$ 0
	Vision Plan #2 Each enrolled family member: $200 frames or contacts In-Network	$ 10.70	$ 9.73	$ 8.92
Group Life VOYA	Employer-sponsored life/accidental death & dismemberment of $50,000 for employee.	$ 0		
Medical Opt-out	Monthly cash incentive for declining medical. Enrollment continues for dental, vision, and life	12 Payments of $375 monthly paid stipend		

Benefitfocus plan names are in red and enclosed in parentheses.

For any questions, please contact – Maria Alvarez at: Benefits@sbcss.net - 909 386-9562.

3/12/2024 – 1:00 pm