SBCSS Health Plans Offered for 2024-2025

SBCTA Employees Only

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

Medical Plan Choices	Total Employee Monthly Cost			
	W/Option A	W/Option B	W/Option C	W/Option D
Kaiser Permanente Options				
Kaiser - Plan #1 (Kaiser Plan 8) *$20 co-payment / Pharmacy $10 Generic / $20 Brand* *100% hospital covered*	$188.78	$196.77	$185.87	$193.86
Kaiser - Plan #2 (Kaiser Plan 12) *$30 co-payment/ Pharmacy $15 Generic/ $30 Brand* *$250 co-payment for hospital admission*	$86.17	$94.16	$83.26	$91.25
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*	$0	$0	$0	$0
Blue Shield HMO Options				
Blue Shield TRIO ACO - Plan #1 (Blue Shield HMO Trio C20) *$20 co-payment /100% hospital covered*	$0	$0	$0	$0
Blue Shield Access Plus - Plan #2 (Blue Shield HMO Access+ C20) *$20 co-payment / $500 co-payment hospital*	$136.59	$144.58	$133.68	$141.67
Blue Shield TRIO ACO - Plan #7 (Blue Shield HMO Trio 7) *$30 co-payment / $500 co-payment hospital*	$0	$0	$0	$0
Blue Shield Access Plus - Plan #7 (Blue Shield HMO Access+ 7) *$30 co-payment / $500 co-payment hospital*	$88.59	$96.58	$85.68	$93.67
Blue Shield PPO Options				
Blue Shield PPO - Plan #1 (Blue Shield PPO Cust 20-500) *$500 single/ $1,000 family* In-Network	$2,205.59	$2,213.58	$2,202.68	$2,210.67
Blue Shield PPO – Plan #1A Tandem (Blue Shield PPO Tandem Cust 20-500) $500 single/ $1,000 family In-Network	$1,978.59	$1,986.58	$1,975.68	$1,983.67
Blue Shield HDHP CSEBA Premier - Plan #2 (Blue Shield Premier PPO Savings 1600) $1,600 single / $3,200 family In-Network	$5.59	$13.58	$2.68	$10.67
Blue Shield HDHP CSEBA Tandem - #2A (Blue Shield PPO Premier Tandem Savings 1600) $1,600 single/ $3,200 family In-network	$0	$0	$0	$0
Blue Shield HRA HDHP Plan – Needles/Trona Only (Blue Shield PPO HRA) $1,500 single/ $3,000 family In-network	$84.59	$92.58	$81.68	$89.67

Delta Dental PPO Options	EYEMED Vision Options
Dental Plan #1 Each enrolled family member: *$2,500 In-Network/$2,000 out-of-network*	**Vision Plan #1** Each enrolled family member is entitled to: $150 frames or contacts In-Network
Dental Plan #2 Each enrolled family member: *$2,000 In-Network/$1,500 out-of-network* ***with ortho***	**Vision Plan #2** Each enrolled family member is entitled to: $200 frames or contacts In-Network
Life Insurance	**Opt-out Option**
Employer-sponsored life/accidental death & dismemberment of $50,000 for employee.	Monthly cash incentive for declining medical. Enrollment continues for dental, vision, and life.

Option Descriptions	
Option A – Dental #1/Vision #1/Life	Option C – Dental #2/Vision #1/Life
Option B – Dental #1/Vision #2/Life	Option D – Dental #2/Vision #2/Life

Benefitfocus plan names are in red and enclosed in parentheses.

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

3/29/2024 – 12:00 pm