Catholic Charities
MARIN ◆ SAN FRANCISCO ◆ SAN MATEO

2024-2025 Benefits Overview & Rates

Effective July 1, 2024 - June 30, 2025

Catholic Charities SF contributes **$1,143.79/month** ($571.89/pay period) = 100% employee-only cost of Kaiser $25 Copay + Dental PPO

To calculate your cost: Subtract $1,143.79 from the monthly premiums of your chosen plan(s)

*Any of the Employer contribution (Flex Credit Dollars) not used towards premiums will be paid as taxable income after a **50%** conversion fee for Non-Union employees and 30% for Union*

Plan Details	Kaiser Permanente www.kp.org (In-Network ONLY. No Out-of-Network except for Emergency Room.)								Blue Shield www.blueshieldca.com/fad/home			
	$25 Copay		$500 Deductible		$1,000 Deductible		HSA		EPO $1,000 (Blue Shield 5139 EPO)		HSA $2,000 (Blue Shield 5069 HSA)	
	4015 KA EPO 0-2-St-CO		4027 KA DEPO 500-1-St-CO		4063 KA DEPO 1000-1-St-CO		4085 KA HSA 1-St-CO		In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible (CYD)												
Individual	None		$500		$1,000		$1,500		$1,000	N/A	$2,000	$1,144
Family (Embedded Indv.)			$1,000		$2,000		$3,000		$2,000		$4,000	$4,000
Calendar Year Out-of-Pocket Maximum (OOPM)										N/A		
Individual	$1,500		$3,000		$4,000		$3,000		$5,000		$6,000	$6,000
Family	$3,000		$6,000		$8,000		$6,000		$10,000		$12,000	$12,000
Doctor Visit Preventative	None		None		None		None		None		None	30% + ded
Primary Care	$25		$20		$25		$20 after deductible		$25	No	10% + Ded	30% + Ded
Specialist	$25		$20		$25		$20 after deductible		$40	Coverage	10% + Ded	30% + Ded
Urgent Care	$25		$20		$25		$20 after deductible		$50		10% + Ded	30% + Ded
Tests												
Labs & X-rays	None		$10 Copay		$10 after deductible		$10 after deductible		20% + Ded	No	10% + Ded	30% + Ded
MRI, CT & PET	None		$50 Copay		$10 after deductible		$10 after deductible		20% + Ded	Coverage	10% + Ded	30% + Ded
Hospital												
Inpatient	$250 / Admission		10% after deductible		10% after deductible		$250 after deductible		20% + Ded	No	10% + Ded	30% + Ded
Outpatient Surgery	$25 Copay		10% after deductible		10% after deductible		$150 after deductible		20% + Ded	Coverage	10% + Ded	30% + Ded
Emergency Room	$100 / Visit		10% after deductible		10% after deductible		$100 after deductible		$200 + 20% + Deductible		10% + Deductible	
Ambulance	$50/Trip		$150/Trip		$150/Trip		$150 after deductible		20% + Deductible		10% + Deductible	
Prescriptions (Rx)	**Generic**	**Brand**	**Generic**	**Brand**	**Generic**	**Brand**	**Generic**	**Brand**	**Gen/Brand/Non-formulary**		**Gen/Brand/Non-formulary**	
Retail	$10	$30	$10	$30	$10	$30	$10 + ded	$30 + ded	$10/$30/$50		$10/$20/$40	
Mail Order	$20	$60	$20	$60	$20	$60	$20 + ded	$60 + ded	$20/$60/$100		$20/$40/$80	
Mental Health (outpatient)	$25 / visit		$20 / visit		$25 / visit		$20 / visit		$25 / visit	N/A	10% + Ded	30% + Ded
Chiropractic	$15 - 24 visits / yr		$15 - 24 visits / yr		$15 - 24 visits / yr		$15 - 24 visits / yr		$40 - 24 visits/yr	N/A	10% + Ded	30% + Ded
Acupuncture	$25 - 24 visits / yr		$25 - 24 visits / yr		$25 - 24 visits / yr		$25 - 24 visits / yr		$40 - 12 visits/yr		10% + Ded	30% + Ded
Optical	Free Exam. $175 allowance towards contacts, lenses, or frames every 24 months.								None		None	
Rates (Premiums)	***Monthly***	*Pay Period*	***Monthly***	*Pay Period*	***Monthly***	*Pay Period*	***Monthly***	*Pay Period*	***Monthly***	*Pay Period*	***Monthly***	*Pay Period*
Employee Only	***$ 1,086.10***	*$ 543.05*	***$ 1,023.69***	*$ 511.85*	***$ 993.77***	*$ 496.89*	***$ 868.91***	*$ 434.46*	***$ 1,414.69***	*$ 707.35*	***$ 1,303.26***	*$ 651.63*
Employee + Spouse	***$ 2,389.45***	*$ 1,194.73*	***$ 2,252.13***	*$ 1,126.07*	***$ 2,186.31***	*$ 1,093.16*	***$ 1,911.60***	*$ 955.80*	***$ 3,112.32***	*$ 1,556.16*	***$ 2,867.39***	*$ 1,433.70*
Employee + Child(ren)	***$ 1,792.10***	*$ 896.05*	***$ 1,689.11***	*$ 844.56*	***$ 1,639.75***	*$ 819.88*	***$ 1,433.72***	*$ 716.86*	***$ 2,334.24***	*$ 1,167.12*	***$ 2,150.54***	*$ 1,075.27*
Employee + Family	***$ 3,041.12***	*$ 1,520.56*	***$ 2,866.33***	*$ 1,433.17*	***$ 2,782.56***	*$ 1,391.28*	***$ 2,432.95***	*$ 1,216.48*	***$ 3,961.14***	*$ 1,980.57*	***$ 3,649.40***	*$ 1,824.70*

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Delta Dental

www.deltadentalins.com

Plan Details	PPO (Delta Dental Plan #3) In-Network	PPO (Delta Dental Plan #3) Out-of-Network	DMO (DeltaCare DMO Group 10A) In-Network Only - must be assigned to DMO dentist
Deductible (waived for Diagnostic & Prev Svcs)			
Individual	$50	$75	None
Family	$150	$225	
Calendar Year Out-of-Pocket Max *(Diagnostic & Prev Svcs goes towards maximum)*	$2,000/person		None
Services	Percentage-based		Fee Structure
Diagnostic	100%	100%	$0 - $5
Preventative			$0 - $45
Basic Services			
Composite fillings	90%	80%	$0 - $195
Endodontics (root canal)	90%	80%	$0 - $220
Periodontics (gum treatment)	90%	80%	$0 - $195
Oral Surgery	90%	80%	$0 - $90
Major Services			
Crowns inlays, onlays, & cast restoration	60%	50%	$0 - $195
Prosthodontics - bridges, dentures, implants	60%	50%	$0 - $195 (implants
Orthodontic Benefits - Adults & dep children	50%	50%	$0 - $1,900
Orthodontic Maximums	$1,500	$1,500	$1,700 - $1,900

Rates (Premiums)	*Monthly*	*Pay Period*	*Monthly*	*Pay Period*
Employee Only	***$ 57.69***	*$ 28.85*	***$ 18.66***	*$ 9.33*
Employee + Spouse	***$ 126.87***	*$ 63.44*	***$ 37.19***	*$ 18.60*
Employee + Child(ren)	***$ 103.82***	*$ 51.91*	***$ 37.19***	*$ 18.60*
Employee + Family	***$ 173.03***	*$ 86.52*	***$ 61.24***	*$ 30.62*

Vision Service Plan (VSP)

www.vsp.com

	In-Network	Out-of-Network	Frequency
Vision Exam	$10 Copay	Call VSP Member Services for out-of-network details	Every 12 months
Contact Lens Vision Exam	Up to $60		Every 12 months
Frames	$150 allowance, $170 featured brands 20% savings on amount over allowance $80 Costco frame allowance		Every 24 months
Lenses	$25 Copay		Every 12 months
Lens Enhancements	$20-$40 Copay		
Contacts *(instead of glasses)*	up to $150 allowance		Every 12 months

Rates (Premiums)	*Monthly*	*Pay Period*
Employee Only	***$ 6.99***	*$ 3.50*
Employee + Spouse	***$ 15.39***	*$ 7.70*
Employee + Child(ren)	***$ 12.60***	*$ 6.30*
Employee + Family	***$ 20.99***	*$ 10.50*

Flexible Spending Account (FSA)

	Health Care FSA	Dependent Care FSA
Annual Max Limit	**$3,200**	**$2,500 ($5,000 household)**
Admin Fee (remains the same)	**$5.20/month** ($2.60/pay period) **$6.35/month** ($3.18/pay period) If enrolled onto both Health & Dep Care FSA	

Health Savings Account (HSA)

HSA's are only available to those enrolled in the Kaiser HSA or Blue Shield HSA plan

	Individual	Family	Addt'l for age 55+
Annual Max Limit	**$4,150**	**$8,300**	**$1,000**

You cannot enroll in both FSA and HSA