

2021 Benefits Rate Sheet (Bi-Weekly) Managers Unit 1, 21, 31 Employees

DENTAL	Tier	Plan Rate (B)
DPO – Delta Preferred Option	<i>Employee Only</i>	\$26.94 <input type="checkbox"/>
	<i>Employee + 1</i>	\$47.67 <input type="checkbox"/>
	<i>Family</i>	\$76.41 <input type="checkbox"/>
HMO – DeltaCare USA	<i>Employee Only</i>	\$8.20 <input type="checkbox"/>
	<i>Employee + 1</i>	\$14.66 <input type="checkbox"/>
	<i>Family</i>	\$21.39 <input type="checkbox"/>

Dental Cost Calculation

Remaining Cafeteria Amount/Deduction from previous page: _____
 Enter Dental Plan Rate (B) - _____
 Remaining Cafeteria Amount/Deduction after Dental = _____

VISION	Tier	Plan Rate (C)
Vision Service Plan	<i>Employee Only</i>	\$3.47 <input type="checkbox"/>
	<i>Employee + 1</i>	\$6.88 <input type="checkbox"/>
	<i>Family</i>	\$10.50 <input type="checkbox"/>

Vision Cost Calculation

Remaining Cafeteria Amount/Deduction from above: _____
 Enter Vision Plan Rate (C) - _____
 Remaining Cafeteria Amount/Deduction after Vision = _____

Waive Medical, Dental & Vision	No Coverage =	\$859.00
Complete Medical Waiver Form, submit to Benefits Office with copy of your member id card.		

*NOTE: CalPERS Region 2 = (Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, San Diego, San Luis Obispo, Santa Barbara, Tulare, and Ventura counties) - Medical rates include Admin Fees for Online Enrollment System

This worksheet is for your own personal use. There is no need to return it to HR/Benefits. The online enrollment system will provide premium calculations based on your plan selections.

Rates effective 01/01/2021 - 12/31/2021

This sheet highlights benefits under the City of Santa Barbara benefit program. It is not intended to help you choose the benefits that are best for you. This sheet does not include plan rules, details and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be any inconsistencies between Open Enrollment guides and the legal plan documents, the plan documents are the final authority.

**2021 Benefits Rate Sheet (Bi-Weekly)
Managers Unit 2, 22, 32 Employees**

Maximum Cafeteria Amount: **\$838.00**

MEDICAL - CalPERS Region 2*	Plan Code	Tier	Plan Rate (A)
Anthem Traditional HMO	2305	Employee Only	\$527.95 <input type="checkbox"/>
	2306	Employee + 1	\$1,052.38 <input type="checkbox"/>
	2307	Family	\$1,367.04 <input type="checkbox"/>
Blue Shield Access+ HMO	2309	Employee Only	\$474.27 <input type="checkbox"/>
	2310	Employee + 1	\$945.02 <input type="checkbox"/>
	2311	Family	\$1,227.47 <input type="checkbox"/>
Blue Shield Trio HMO	TBD	Employee Only	\$365.78 <input type="checkbox"/>
	TBD	Employee + 1	\$728.03 <input type="checkbox"/>
	TBD	Family	\$945.39 <input type="checkbox"/>
Anthem Select HMO <i>Ventura County Only</i>	2301	Employee Only	\$341.78 <input type="checkbox"/>
	2302	Employee + 1	\$680.03 <input type="checkbox"/>
	2303	Family	\$882.98 <input type="checkbox"/>
Kaiser Permanente HMO <i>Ventura County Only</i>	2316	Employee Only	\$339.31 <input type="checkbox"/>
	2317	Employee + 1	\$675.10 <input type="checkbox"/>
	2318	Family	\$876.57 <input type="checkbox"/>
United HealthCare HMO <i>Ventura County Only</i>	2342	Employee Only	\$366.42 <input type="checkbox"/>
	2343	Employee + 1	\$729.31 <input type="checkbox"/>
	2344	Family	\$947.05 <input type="checkbox"/>
PERS Select PPO	2327	Employee Only	\$242.62 <input type="checkbox"/>
	2328	Employee + 1	\$481.73 <input type="checkbox"/>
	2329	Family	\$625.19 <input type="checkbox"/>
PERS Choice PPO	2323	Employee Only	\$396.17 <input type="checkbox"/>
	2324	Employee + 1	\$788.82 <input type="checkbox"/>
	2325	Family	\$1,024.41 <input type="checkbox"/>
PERSCare PPO	2331	Employee Only	\$562.87 <input type="checkbox"/>
	2332	Employee + 1	\$1,122.21 <input type="checkbox"/>
	2333	Family	\$1,457.82 <input type="checkbox"/>
PORAC Region 2 <i>PORAC Safety Members Only</i>	2331	Employee Only	\$379.03 <input type="checkbox"/>
	2332	Employee + 1	\$755.04 <input type="checkbox"/>
	2333	Family	\$986.17 <input type="checkbox"/>

Medical Cost Calculation

Maximum Cafeteria Amount: \$838.00

Enter Medical Plan Rate (A) - _____

Remaining Cafeteria Amount/Deduction after Medical = _____

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	<i>Family</i>	\$76.41 <input type="checkbox"/>
HMO – DeltaCare USA	<i>Employee Only</i>	\$8.20 <input type="checkbox"/>
	<i>Employee + 1</i>	\$14.66 <input type="checkbox"/>
	<i>Family</i>	\$21.39 <input type="checkbox"/>

Dental Cost Calculation

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VISION	Tier	Plan Rate (C)
Vision Service Plan	<i>Employee Only</i>	\$3.47 <input type="checkbox"/>
	<i>Employee + 1</i>	\$6.88 <input type="checkbox"/>
	<i>Family</i>	\$10.50 <input type="checkbox"/>

Vision Cost Calculation

Remaining Cafeteria Amount/Deduction from above: _____
 Enter Vision Plan Rate (C) - _____
 Remaining Cafeteria Amount/Deduction after Vision = _____

Waive Medical, Dental & Vision	No Coverage =	\$838.00
Complete Medical Waiver Form, submit to Benefits Office with copy of your member id card.		

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