SETA

Health Insurance Rate Sheet Effective January 1, 2024

HMO Coverage Options

	Bi-Weekly		Monthly		Total Premium	Delta Dental EE Monthly Cost	HSA Health Savings Account	Optional Vision Services EE Monthly Cost	OR	Vision Enhancement (ILO other Optional) EE Monthly Cost
	EE Cost	SETA Cost	EE Cost	SETA Cost						
Kaiser										
Single - Employee Only	$212.93	$362.50	$425.86	$725.00	$1,150.86	$0.00	N/A	$5.16		$9.94
Family - Employee w/dependent	$711.49	$760.00	$1,422.98	$1,520.00	$2,942.98	$0.00		$13.22		$25.47
Sutter Health Plus										(enhancement addt'l EE Cost)
Single - Employee Only	$112.18	$362.50	$224.36	$725.00	$949.36	$0.00	N/A	**Included**		$4.78
Family - Employee w/dependent	$455.16	$760.00	$910.32	$1,520.00	$2,430.32	$0.00				$12.25
Western Health Advantage										(enhancement addt'l EE Cost)
Single - Employee Only	$66.43	$362.50	$132.86	$725.00	$857.86	$0.00	N/A	**Included**		$4.78
Family - Employee w/dependent	$338.11	$760.00	$676.22	$1,520.00	$2,196.22	$0.00				$12.25

High Deductible Coverage Options

	Bi-Weekly		Monthly		Total Premium	Delta Dental EE Monthly Cost	HSA Health Savings Account	Optional Vision Services EE Monthly Cost	OR	Vision Enhancement (ILO other Optional) EE Monthly Cost
	EE Cost	SETA Cost	EE Cost	SETA Cost						
Kaiser										
Single - Employee Only	$48.66	$362.50	$97.32	$725.00	$822.32	$0.00	Optum	$5.16		$9.94
Family - Employee w/dependent	$291.42	$760.00	$582.84	$1,520.00	$2,102.84	$0.00	Optum	$13.22		$25.47
Sutter Health Plus										
Single - Employee Only	$0.00	$350.05	$0.00	$700.10	$700.10	$0.00	Optum	$5.16		$9.94
Family - Employee w/dependent	$136.15	$760.00	$272.30	$1,520.00	$1,792.30	$0.00	Optum	$13.22		$25.47
Western Health Advantage										
Single - Employee Only	$0.00	$327.75	$0.00	$655.50	$655.50	$0.00	Health Equity	$5.16		$9.94
Family - Employee w/dependent	$79.05	$760.00	$158.10	$1,520.00	$1,678.10	$0.00	Health Equity	$13.22		$25.47

Group Coverage Waived (must attest to having coverage elsewere)	Delta Dental EE Monthly Cost	HSA	Optional Vision Services EE Monthly Cost	OR	Vision Enhancement (ILO other Optional) EE Monthly Cost
Single - Employee Only	$0.00	N/A	$5.16		$9.94
Family - Employee w/dependent	$0.00		$13.22		$25.47

OPTIONAL COVERAGES AVAILABLE