2020 CONTRA COSTA COUNTY
MONTHLY DENTAL PLAN PREMIUMS

EMPLOYEES REPRESENTED BY
DISTRICT ATTORNEY INVESTIGATORS' ASSOCIATION

DEDUCTIONS EFFECTIVE JANUARY 1, 2020

PLAN/COVERAGE DESCRIPTION		TOTAL MONTHLY PREMIUM	COUNTY MONTHLY SUBSIDY	EMPLOYEE MONTHLY SHARE
DELTA DENTAL PREMIER PPO - $1,600 ANNUAL MAXIMUM- INCLUDES ORTHODONTIC BENEFIT*				
For CCHP Alternate A Plan	Employee	$46.36	$33.81	$12.55
	Employee + 1	$117.51	$76.48	$41.03
	Family + 2 or more	$117.51	$76.48	$41.03
For CalPERS Health Plans	Employee	$46.36	$33.81	$12.55
	Employee + 1	$117.51	$76.48	$41.03
	Family + 2 or more	$117.51	$76.48	$41.03
Without a Health Plan	Employee	$46.36	$43.56	$2.80
	Employee + 1	$117.51	$98.46	$19.05
	Family + 2 or more	$117.51	$98.46	$19.05
DELTA CARE (HMO)				
For CCHP Alternate A Plan	Employee	$29.06	$22.30	$6.76
	Employee + 1	$62.81	$48.19	$14.62
	Family + 2 or more	$62.81	$48.19	$14.62
For CalPERS Health Plans	Employee	$29.06	$22.30	$6.76
	Employee + 1	$62.81	$48.19	$14.62
	Family + 2 or more	$62.81	$48.19	$14.62
Without a Health Plan	Employee	$29.06	$28.91	$0.15
	Employee + 1	$62.81	$62.49	$0.32
	Family + 2 or more	$62.81	$62.49	$0.32

* EMPLOYEE MONTHLY SHARE INCLUDES COST OF ORTHODONTIC BENEFIT

VSP VOLUNTARY VISION PLAN				
	Employee	$10.08	$0.00	$10.08
	Employee + 1	$20.14	$0.00	$20.14
	Employee + 2 or more	$32.44	$0.00	$32.44