

PERMANENT FULL TIME EMPLOYEES AND PART TIME EMPLOYEES SCHEDULED TO WORK AT LEAST 16 HOURS PER WEEK

PLAN/COVERAGE DESCRIPTION	2020 TOTAL MONTHLY PREMIUM	2020 COUNTY MONTHLY SUBSIDY	2020 EMPLOYEE MONTHLY SHARE	
CONTRA COSTA HEALTH PLAN - BASIC PLAN A				
Employee on Basic Plan	\$962.77	\$943.52	\$19.25	
Employee & 1 or more dependents on Basic Plan	\$2,293.83	\$2,247.96	\$45.87	
CONTRA COSTA HEALTH PLAN - BASIC PLAN B				
Employee on Basic Plan	\$1,067.24	\$1,045.90	\$21.34	
Employee & 1 or more dependents on Basic Plan	\$2,535.93	\$2,485.22	\$50.71	
KAISER PERMANENTE - BASIC PLAN A				
Employee on Basic Plan	\$960.76	\$768.61	\$192.15	
Employee & 1 or more dependents on Basic Plan	\$2,238.57	\$1,790.86	\$447.71	
KAISER PERMANENTE - BASIC PLAN B				
Employee on Basic Plan	\$783.35	\$626.68	\$156.67	
Employee & 1 or more dependents on Basic Plan	\$1,825.21	\$1,460.17	\$365.04	
HEALTH NET HMO PLAN - BASIC PLAN A				
Employee on Basic Plan	\$1,885.66	\$1,508.53	\$377.13	
Employee & 1 or more dependents on Basic Plan	\$4,619.87	\$3,695.90	\$923.97	
HEALTH NET HMO PLAN - BASIC PLAN B				
Employee on Basic Plan	\$1,311.25	\$1,049.00	\$262.25	
Employee & 1 or more dependents on Basic Plan	\$3,212.56	\$2,570.05	\$642.51	
HEALTH NET PPO PLAN - BASIC PLAN A				
Employee on PPO Basic Plan	\$2,783.36	\$1,462.78	\$1,320.58	
Employee & 1 or more dependents on PPO Basic Plan	\$6,624.40	\$3,481.06	\$3,143.34	
DELTA DENTAL PREMIER PPO - \$1,800 Annual Maximum				
For CCHP Plans	Employee	\$46.52	\$45.59	\$0.93
	Family	\$105.08	\$102.98	\$2.10
For Health Net Plans	Employee	\$46.52	\$36.29	\$10.23
	Family	\$105.08	\$81.97	\$23.11
For Kaiser Permanente Plans	Employee	\$46.52	\$36.29	\$10.23
	Family	\$105.08	\$81.97	\$23.11
Without a Health Plan	Employee	\$46.52	\$46.51	\$0.01
	Family	\$105.08	\$105.07	\$0.01
DELTA CARE (HMO)				
For CCHP Plans	Employee	\$29.06	\$28.48	\$0.58
	Family	\$62.81	\$61.55	\$1.26
For Health Net Plans	Employee	\$29.06	\$22.67	\$6.39
	Family	\$62.81	\$48.99	\$13.82
For Kaiser Permanente Plans	Employee	\$29.06	\$22.67	\$6.39
	Family	\$62.81	\$48.99	\$13.82
Without a Health Plan	Employee	\$29.06	\$29.05	\$0.01
	Family	\$62.81	\$62.80	\$0.01
VSP VOLUNTARY VISION PLAN				
	Employee	\$10.08	\$0.00	\$10.08
	Family	\$27.80	\$0.00	\$27.80