

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

PLAN/COVERAGE DESCRIPTION	2021 TOTAL MONTHLY PREMIUM	2021 COUNTY MONTHLY SUBSIDY	2021 EMPLOYEE MONTHLY SHARE	
CONTRA COSTA HEALTH PLAN - BASIC PLAN A				
Employee on Basic Plan	\$1,056.79	\$1,035.66	\$21.13	
Employee & 1 or more dependents on Basic Plan	\$2,517.84	\$2,467.49	\$50.35	
CONTRA COSTA HEALTH PLAN - BASIC PLAN B				
Employee on Basic Plan	\$1,171.46	\$1,148.04	\$23.42	
Employee & 1 or more dependents on Basic Plan	\$2,783.58	\$2,727.91	\$55.67	
KAISER PERMANENTE - BASIC PLAN A				
Employee on Basic Plan	\$993.36	\$794.69	\$198.67	
Employee & 1 or more dependents on Basic Plan	\$2,314.54	\$1,851.64	\$462.90	
KAISER PERMANENTE - BASIC PLAN B				
Employee on Basic Plan	\$809.92	\$647.94	\$161.98	
Employee & 1 or more dependents on Basic Plan	\$1,887.12	\$1,509.70	\$377.42	
HEALTH NET HMO PLAN - BASIC PLAN A				
Employee on Basic Plan	\$1,861.66	\$1,489.33	\$372.33	
Employee & 1 or more dependents on Basic Plan	\$4,561.07	\$3,648.86	\$912.21	
HEALTH NET HMO PLAN - BASIC PLAN B				
Employee on Basic Plan	\$1,294.56	\$1,035.65	\$258.91	
Employee & 1 or more dependents on Basic Plan	\$3,171.67	\$2,537.34	\$634.33	
HEALTH NET PPO PLAN - BASIC PLAN A				
Employee on PPO Basic Plan	\$3,068.33	\$1,605.27	\$1,463.06	
Employee & 1 or more dependents on PPO Basic Plan	\$7,302.63	\$3,820.18	\$3,482.45	
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	\$46.52	\$0.00
	Family	\$105.08	\$105.08	\$0.00
DELTA CARE (HMO)				
For CCHP Plans	Employee	\$25.35	\$24.85	\$0.50
	Family	\$54.78	\$53.69	\$1.09
For Health Net Plans	Employee	\$25.35	\$19.78	\$5.57
	Family	\$54.78	\$42.73	\$12.05
For Kaiser Permanente Plans	Employee	\$25.35	\$19.78	\$5.57
	Family	\$54.78	\$42.73	\$12.05
Without a Health Plan	Employee	\$25.35	\$25.35	\$0.00
	Family	\$54.78	\$54.78	\$0.00
VSP VOLUNTARY VISION PLAN				
	Employee	\$10.08	\$0.00	\$10.08
	Family	\$27.80	\$0.00	\$27.80