

**GOVERNMENT ATTORNEYS ASSOCIATION  
MONTHLY PREMIUMS & COUNTY CONTRIBUTIONS  
FOR CALENDAR YEAR 2022**

*County contribution based on 95/90/90 of the 2021 premium for Kaiser HMO*

| 2022 MONTHLY COUNTY CONTRIBUTIONS |         |          |
|-----------------------------------|---------|----------|
|                                   | MEDICAL | FHA      |
| EE                                | 149.00  | 623.96   |
| EE + 1                            | 149.00  | 1,315.55 |
| EE + 2                            | 149.00  | 1,754.91 |

| Monthly Premium | MONTHLY COUNTY CONTRIBUTIONS AVAILABLE FOR MEDICAL PREMIUMS |                                 |                        | EE MONTHLY COSTS |                                   |               | EE PAY PERIOD COST |
|-----------------|---|---------------------------------|------------------------|------------------|-----------------------------------|---------------|--------------------|
|                 | TOTAL *1 Contribution                                       | = Medical Contribution (PEMHCA) | + FHA **2 Contribution | EE Cost For Plan | EE Cost Admin<br>0.25% of premium | Total EE Cost |                    |

**BLUE SHIELD ACCESS+ HMO (Palo Alto Medical Foundation and Dignity Health Medical Network)**

|        |          |          |        |          |        |      |          |        |
|--------|----------|----------|--------|----------|--------|------|----------|--------|
| EE     | 1,116.01 | 772.96   | 149.00 | 623.96   | 343.05 | 2.79 | 345.84   | 172.92 |
| EE + 1 | 2,232.02 | 1,464.55 | 149.00 | 1,315.55 | 767.47 | 5.58 | 773.05   | 386.53 |
| EE + 2 | 2,901.63 | 1,903.91 | 149.00 | 1,754.91 | 997.72 | 7.25 | 1,004.97 | 502.49 |

**BLUE SHIELD TRIO HMO (Dignity Health Medical Network)**

|        |          |          |        |          |        |      |        |        |
|--------|----------|----------|--------|----------|--------|------|--------|--------|
| EE     | 898.54   | 772.96   | 149.00 | 623.96   | 125.58 | 2.25 | 127.83 | 63.91  |
| EE + 1 | 1,797.08 | 1,464.55 | 149.00 | 1,315.55 | 332.53 | 4.49 | 337.02 | 168.51 |
| EE + 2 | 2,336.20 | 1,903.91 | 149.00 | 1,754.91 | 432.29 | 5.84 | 438.13 | 219.07 |

**ANTHEM HMO SELECT (Dignity Health Medical Network)**

|        |          |          |        |          |        |      |        |        |
|--------|----------|----------|--------|----------|--------|------|--------|--------|
| EE     | 1,015.81 | 772.96   | 149.00 | 623.96   | 242.85 | 2.54 | 245.39 | 122.69 |
| EE + 1 | 2,031.62 | 1,464.55 | 149.00 | 1,315.55 | 567.07 | 5.08 | 572.15 | 286.07 |
| EE + 2 | 2,641.11 | 1,903.91 | 149.00 | 1,754.91 | 737.20 | 6.60 | 743.80 | 371.90 |

**ANTHEM HMO TRADITIONAL (Palo Alto Medical Foundation and Dignity Health Medical Network)**

|        |          |          |        |          |          |      |          |        |
|--------|----------|----------|--------|----------|----------|------|----------|--------|
| EE     | 1,304.00 | 772.96   | 149.00 | 623.96   | 531.04   | 3.26 | 534.30   | 267.15 |
| EE + 1 | 2,608.00 | 1,464.55 | 149.00 | 1,315.55 | 1,143.45 | 6.52 | 1,149.97 | 574.99 |
| EE + 2 | 3,390.40 | 1,903.91 | 149.00 | 1,754.91 | 1,486.49 | 8.48 | 1,494.97 | 747.48 |

**HEALTHNET SMARTCARE HMO (Dignity Health Medical Network)**

|        |          |          |        |          |          |      |          |        |
|--------|----------|----------|--------|----------|----------|------|----------|--------|
| EE     | 1,153.00 | 772.96   | 149.00 | 623.96   | 380.04   | 2.88 | 382.92   | 191.46 |
| EE + 1 | 2,306.00 | 1,464.55 | 149.00 | 1,315.55 | 841.45   | 5.77 | 847.22   | 423.61 |
| EE + 2 | 2,997.80 | 1,903.91 | 149.00 | 1,754.91 | 1,093.89 | 7.49 | 1,101.38 | 550.69 |

**KAISER HMO**

|        |          |          |        |          |        |      |        |        |
|--------|----------|----------|--------|----------|--------|------|--------|--------|
| EE     | 857.06   | 772.96   | 149.00 | 623.96   | 84.10  | 2.14 | 86.24  | 43.12  |
| EE + 1 | 1,714.12 | 1,464.55 | 149.00 | 1,315.55 | 249.57 | 4.29 | 253.86 | 126.93 |
| EE + 2 | 2,228.36 | 1,903.91 | 149.00 | 1,754.91 | 324.45 | 5.57 | 330.02 | 165.01 |

**PERS GOLD PPO (formerly PERS Select) (not contracted with PAMF, subject to Non-PPO charges)**

|        |          |          |        |          |      |      |      |      |
|--------|----------|----------|--------|----------|------|------|------|------|
| EE     | 701.23   | 701.23   | 149.00 | 552.23   | 0.00 | 1.75 | 1.75 | 0.88 |
| EE + 1 | 1,402.46 | 1,402.46 | 149.00 | 1,253.46 | 0.00 | 3.51 | 3.51 | 1.75 |
| EE + 2 | 1,823.20 | 1,823.20 | 149.00 | 1,674.20 | 0.00 | 4.56 | 4.56 | 2.28 |

**PERS PLATINUM PPO (formerly PERSCare and PERS Choice)**

|        |          |          |        |          |        |      |        |        |
|--------|----------|----------|--------|----------|--------|------|--------|--------|
| EE     | 1,057.01 | 772.96   | 149.00 | 623.96   | 284.05 | 2.64 | 286.69 | 143.35 |
| EE + 1 | 2,114.02 | 1,464.55 | 149.00 | 1,315.55 | 649.47 | 5.29 | 654.76 | 327.38 |
| EE + 2 | 2,748.23 | 1,903.91 | 149.00 | 1,754.91 | 844.32 | 6.87 | 851.19 | 425.60 |

**PORAC (available to only PORAC Association members)**

|        |          |          |        |          |        |      |        |        |
|--------|----------|----------|--------|----------|--------|------|--------|--------|
| EE     | 799.00   | 772.96   | 149.00 | 623.96   | 26.04  | 2.00 | 28.04  | 14.02  |
| EE + 1 | 1,725.00 | 1,464.55 | 149.00 | 1,315.55 | 260.45 | 4.31 | 264.76 | 132.38 |
| EE + 2 | 2,219.00 | 1,903.91 | 149.00 | 1,754.91 | 315.09 | 5.55 | 320.64 | 160.32 |

**DELTA PREFERRED OPTION (DPO) PLUS DENTAL COVERAGE**

|  |       |       |
|--|-------|-------|
| EE+1 OR MORE DEPENDENTS - ONE FULL YEAR OF ENROLLMENT REQUIRED | 48.00 | 24.00 |
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**VISION SERVICE PLAN**

|  |       |      |
|--|-------|------|
| 1 OR MORE DEPENDENTS -- ONE FULL YEAR OF ENROLLMENT REQUIRED | 17.84 | 8.92 |
|--|-------|------|

EE = employee only

EE+1 = employee plus one dependent

EE+2 = employee plus two or more dependents.

| MONTHLY COUNTY CONTRIBUTION<br>RETIREE MEDICAL |        |
|--|--------|
| RETIREE  | 149.00 |

\*1 TOTAL COUNTY CONTRIBUTION FOR EACH ENROLLMENT TIER IS THE MEDICAL (PEMHCA MINIMUM) AMOUNT PLUS THE FHA CONTRIBUTION AMOUNT FOR EACH CORRESPONDING ENROLLMENT TIER.

\*\*2 FLEXIBLE HEALTH ALLOWANCE (FHA) CONTRIBUTION AMOUNT IS CONTAINED IN EACH ENROLLMENT TIER. EMPLOYEES MAY USE ALL OR PART OF THEIR FHA TO PURCHASE MEDICAL, DPO PLUS DENTAL AND/OR DEPENDENT VISION. UNUSED FHA WILL BE FORFEITED. EMPLOYEES MUST BE ENROLLED IN A COUNTY MEDICAL PLAN TO PARTICIPATE.

FHA MAY NOT BE APPLIED TO CALPERS ADMIN FEE.