

DEDUCTIONS EFFECTIVE JANUARY 1, 2023

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	\$25.35	\$22.30	\$3.05
	Employee + 1	\$54.78	\$48.19	\$6.59
	Family + 2 or more	\$54.78	\$48.19	\$6.59
For CalPERS Health Plans	Employee	\$25.35	\$22.30	\$3.05
	Employee + 1	\$54.78	\$48.19	\$6.59
	Family + 2 or more	\$54.78	\$48.19	\$6.59
Without a Health Plan	Employee	\$25.35	\$25.35	\$0.00
	Employee + 1	\$54.78	\$54.78	\$0.00
	Family + 2 or more	\$54.78	\$54.78	\$0.00
* EMPLOYEE MONTHLY SHARE INCLUDES COST OF ORTHODONTIC BENEFIT				
VSP VOLUNTARY VISION PLAN				
	Employee	\$9.00	\$0.00	\$9.00
	Employee + 1	\$17.99	\$0.00	\$17.99
	Employee + 2 or more	\$28.98	\$0.00	\$28.98