

**DEDUCTIONS EFFECTIVE JANUARY 1, 2024**

<b>PLAN/COVERAGE DESCRIPTION</b>		<b>TOTAL MONTHLY PREMIUM</b>	<b>COUNTY MONTHLY SUBSIDY</b>	<b>EMPLOYEE MONTHLY SHARE</b>
<b>DELTA DENTAL PREMIER PPO - \$1,800 ANNUAL MAXIMUM</b>				
For CCHP Alternate A Plan	Employee	\$46.52	\$41.85	\$4.67
	Employee + 1	\$105.08	\$94.54	\$10.54
	Family + 2 or more	\$105.08	\$94.54	\$10.54
For CalPERS Health Plans	Employee	\$46.52	\$34.70	\$11.82
	Employee + 1	\$105.08	\$78.31	\$26.77
	Family + 2 or more	\$105.08	\$78.31	\$26.77
Without a Health Plan	Employee	\$46.52	\$44.03	\$2.49
	Employee + 1	\$105.08	\$99.35	\$5.73
	Family + 2 or more	\$105.08	\$99.35	\$5.73
<b>DELTA CARE (HMO)</b>				
For CCHP Alternate A Plan	Employee	\$24.17	\$24.17	\$0.00
	Employee + 1	\$52.23	\$52.23	\$0.00
	Family + 2 or more	\$52.23	\$52.23	\$0.00
For CalPERS Health Plans	Employee	\$24.17	\$21.31	\$2.86
	Employee + 1	\$52.23	\$46.05	\$6.18
	Family + 2 or more	\$52.23	\$46.05	\$6.18
Without a Health Plan	Employee	\$24.17	\$24.17	\$0.00
	Employee + 1	\$52.23	\$52.23	\$0.00
	Family + 2 or more	\$52.23	\$52.23	\$0.00
<b>VSP VOLUNTARY VISION PLAN</b>				
	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