

**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	\$41.17	\$5.35
	Employee + 1	\$105.08	\$93.00	\$12.08
	Family + 2 or more	\$105.08	\$93.00	\$12.08
For CalPERS Health Plans	Employee	\$46.52	\$34.02	\$12.50
	Employee + 1	\$105.08	\$76.77	\$28.31
	Family + 2 or more	\$105.08	\$76.77	\$28.31
Without a Health Plan	Employee	\$46.52	\$43.35	\$3.17
	Employee + 1	\$105.08	\$97.81	\$7.27
	Family + 2 or more	\$105.08	\$97.81	\$7.27
<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 mo	\$28.98	\$0.00	\$28.98