DEDUCTIONS EFFECTIVE JANUARY 1, 2024

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	$24.17	$22.30	$1.87
	Employee + 1	$52.23	$48.19	$4.04
	Family + 2 or more	$52.23	$48.19	$4.04
For CalPERS Health Plans	Employee	$24.17	$22.30	$1.87
	Employee + 1	$52.23	$48.19	$4.04
	Family + 2 or more	$52.23	$48.19	$4.04
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

* 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