GENERAL UNIT - 2024

VISION

EYEMED VISION				
	PLAN CODE	GROSS MONTHLY PREMIUM	MONTHLY EMPLOYEE COST	BI-WEEKLY DEDUCTION
Emp. Only	EYE1	$7.98	$0.00	$0.00
Emp. & Spouse	EYE2	$14.36	$6.38	$3.19
Emp & Child(ren)	EYE4	$14.07	$6.10	$3.05
Emp & Family	EYE3	$20.59	$12.62	$6.31

DENTAL

DELTA DENTAL PPO				
	PLAN CODE	GROSS MONTHLY PREMIUM	MONTHLY EMPLOYEE COST	BI-WEEKLY DEDUCTION
Emp. Only	DPP1	$43.60	$43.60	$21.80
Emp. & Spouse	DPP2	$83.50	$83.50	$41.75
Emp & Child(ren)	DPP4	$78.10	$78.10	$39.05
Emp & Family	DPP3	$118.60	$118.60	$59.30

DELTA DENTAL HMO				*(Their clinics only)*
	PLAN CODE	GROSS MONTHLY PREMIUM	MONTHLY EMPLOYEE COST	BI-WEEKLY DEDUCTION
Emp. Only	DHM1	$16.80	$16.80	$8.40
Emp. & 1 Dep.	DHM2	$29.80	$29.80	$14.90
Emp & 2+ Deps.	DHM3	$43.90	$43.90	$21.95

This information is current as of 10/16/23 and is subject to change based on premium changes by the vendors or EE cost changes resulting from action by the Board of Supervisors.

To calculate your bi-weekly deduction use the following formula: Health Deduction + Vision Deduction + Dental Deduction = Total Deduction