

# NON-REPRESENTED - 2024

## VISION

<b>EYEMED VISION</b>				
	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

<b>DELTA DENTAL PPO</b>				
	PLAN CODE	GROSS MONTHLY PREMIUM	MONTHLY EMPLOYEE COST	BI-WEEKLY DEDUCTION
Emp. Only	DPP1	\$43.60	\$0.00	\$0.00
Emp. & Spouse	DPP2	\$83.50	\$39.90	\$19.95
Emp & Child(ren)	DPP4	\$78.10	\$34.50	\$17.25
Emp & Family	DPP3	\$118.60	\$75.00	\$37.50

<b>DELTA DENTAL HMO</b>				
				Their Clinics Only
	PLAN CODE	GROSS MONTHLY PREMIUM	MONTHLY EMPLOYEE COST	BI-WEEKLY DEDUCTION
Emp. Only	DHM1	\$16.80	\$0.00	\$0.00
Emp. & 1 Dep.	DHM2	\$29.80	\$0.00	\$0.00
Emp & 2+ Deps.	DHM3	\$43.90	\$0.30	\$0.15

**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