

FY 2022-2023 H&W CALCULATION
Annual District Cap \$ 17,600.00
Monthly District \$1,466.67
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FACULTY	Plan Type	Brief Description of Coverage, for more details please see accompanying CVT booklet					
		10thly	Deductible	Primary Care Visit Co-Pay	Hospital Stay	Prescription Drugs (Retail)	Additional Details
		PREMIUM RATE					
CVT BRONZE MONTHLY	PPO	\$0	\$5,000 Individual, \$10,000 Family	\$60 Copay or 70% after Deductible	70% after Deductible	\$25 Generic/\$50 Brand, after Deductible	
HDHP 1 SINGLE	H.S.A/PPO	\$0	\$1,400 Individual	90% after Deductible	90% after Deductible	90% after Deductible	Health Savings Account included, not to exceed \$1,500 annually, restrictions apply
HDHP 1 FAMILY	H.S.A/PPO	\$145.75	\$2,800 Family	90% after Deductible	90% after Deductible	90% after Deductible	Health Savings Account included, not to exceed \$3,000 annually, restrictions apply
KAISER	HMO	\$0.00	\$0	\$10 Copay	100%	\$5 Generic, \$10 Brand	Only available to employees who live within Kaiser Service Area
2D	PPO	\$785.94	\$0	\$20 Copay	100%	\$10 Generic, \$40 Preferred, \$100 Non- Preferred	
3C	PPO	\$778.74	\$100 Individual, \$200 Family	\$20 Copay	100% after Deductible	\$7 Generic, \$25 Preferred, \$40 Non- Preferred	
5A	PPO	\$697.14	\$100 Individual, \$200 Family	\$30 Copay	90% after Deductible	\$5 Generic, \$22 Brand	
7D	PPO	\$415.14	\$250 Individual, \$500 Family	\$30 Copay	80% after Deductible	\$10 Generic, \$40 Preferred, \$100 Non- Preferred	

Please Note: Rates are subject to change July 2023 due to Dental/Vision Rate Renewal