



**AVCFT: ADJUNCT FACULTY EMPLOYEES
2024 - 2025 HEALTH PLAN ELECTION FORM**

To make your selection: Check the box for your selected plan, sign, date and return to HR - Benefits.

Effective 10/1/2024 for Open Enrollment changes or 9/1/24 for new Fall Enrollees

ADJUNCT FACULTY MUST MEET THE FOLLOWING: The District will pay 50% of the premium for any of the health insurance programs for adjunct faculty who have **no other access** to health insurance **and** who are working **at least 6.0 LHE** or the equivalent load for non-classroom adjunct faculty (40% of full-time load).

Qualified Adjuncts who elect health coverage (except HSA \$5,000 plan) **MUST** carry dental and vision coverage. Dental and vision premiums will be paid by the adjunct faculty member.

BENEFIT PLANS:	Amount per Month Pre-Tax Employee Premium Deduction:	Selection:
PPO PLAN PROVIDER - ANTHEM BLUE CROSS		
40463A BC PPO 100%-A, \$20 Co-pay, Rx \$5-\$20, \$0 Ind./\$0 Fam. Deductible	\$943.00	
40463B BC PPO 100%-B, \$20 Co-pay, Rx \$200/\$10-\$35, \$100 Ind./\$300 Fam. Deductible	\$884.00	
40463C BC PPO 80%-C, \$20 Co-pay, Rx \$5-\$20, \$200 Ind./\$500 Fam. Deductible	\$843.00	
40463D BC PPO 80%-K, \$30 Co-pay, Rx \$9-\$35, \$1,000 Ind./\$2,000 Fam. Deductible	\$711.50	
70112B- HSA \$5000 PLAN- EMPLOYEE ONLY BC 70% & Rx \$9-\$35 after deductible, \$5,000 Ind./\$10,000 Fam. Deductible	\$325.00 NO DENTAL/VISION	
70112B- HSA \$5000 PLAN- EMP. & CHILD(REN) BC 70% & Rx \$9-\$35 after deductible, \$5,000 Ind./\$10,000 Fam. Deductible	\$518.00 NO DENTAL/VISION	
HMO PLAN PROVIDER - KAISER PERMANENTE		
234480-0027 / ACN Kaiser HMO w/ Chiro, \$10 Co-Pay, Rx \$10, \$0 Ind./\$0 Fam. Deductible	\$743.00	
234480-0028 / ACN Kaiser HMO w/ Chiro, \$20 Co-Pay, Rx \$10-\$20, Ind. \$0/Fam. \$0 Deductible	\$727.00	
DENTAL PLAN PROVIDER - DELTA DENTAL		
7079 1300 (Dental Option 1) DD PPO Incentive Plan- \$2,000 max. per year, 3rd Cleaning, Ortho: Adults & Children (Life max \$1,500)	\$117.90	
7079 1350 (Dental Option 2) DD PPO Plan- \$1,500 max. per year	\$85.00	
VISION PLAN PROVIDER - VISION SERVICE PLAN		
2536/64253ACN VSP Signature Plan C- \$5 Co-pay, Exam, Frames & Lenses every year, 2nd Pair	\$28.20	

PAYROLL DEDUCTION AUTHORIZATION: I understand that the employee premium applicable to the plan I have selected will be made through a payroll deduction. All deductions are processed pre-otherwise requested. If post-tax option is requested you must meet with Human Resources to complete required documents.

Employee Printed Name: _____ **SSN/Employee 900 #:** _____

Employee Signature (required): _____ **Date:** _____

Phone Number/Email: _____

BENEFIT DEDUCTIONS: All benefit deductions are 12 months. Deductions begin with the Oct. 5th payroll for new Fall enrollees or the Nov. 5th payroll for continuing enrollees. It is the employee's responsibility to notify HR if the employee will fail to meet the qualification requirement for an upcoming semester. The district will pay **no portion** of benefits for any term (including Summer) in which the employee is not qualified.

PREMIUMS: All medical, dental, and vision plans are composite based (fixed rate regardless of number of dependents).

PLAN CHANGES: ONLY within 30 days of a qualifying event, or open enrollment (July/Aug. of each year). Open enrollment changes are effective Oct. 1st.

COORDINATION OF COVERAGE: Kaiser, as an HMO, does not coordinate benefits with Blue Cross/Blue Shield plans. Spouses not primarily covered on an HMO are limited to the use of their own plans. Dependents of parents having both a PPO plan and an HMO are provided primary coverage based on the parent whose birthdate falls earliest in the calendar year, as is the case with both parents having PPO plans.

NEW EMPLOYEES: Coverage begins the **first of the month following start date.**

RESIGNATION/TERMINATION: Benefits stop on the **last day of the month the employee worked & applicable premiums were deducted.**



Antelope Valley Community College District
Faculty Plan Matrix for 2024/2025

	Anthem					Kaiser	
	100-A \$20 40463A	100-B \$20 40463B	80-C \$20 40463C	80-K \$30 40463D	Two-Tier HSA \$5000 70112B	Trad HMO \$10 234480-0027/ACN	Trad HMO \$20 234480-0028/ACN
MEDICAL - CALENDAR YEAR Deductibles & Maximums	Member Pays					Member Pays	
Individual/Family Deductibles	\$0/\$0	\$100/\$300	\$200/\$500	\$1,000/\$2,000	\$5,000/\$10,000*	\$0	
Individual/Family Out-of-Pocket (OOP) Max <i>(includes medical deductibles, co-insurance and co-pays)</i>	\$1,000/\$3,000			\$3,000/\$6,000	\$6,350/\$12,700*	\$1,500/\$3,000	

*Includes Rx

PROFESSIONAL SERVICES

Office Visit (OV) co-pay (\$0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)	\$20	\$30	Deductible, then 30%	\$10	\$20
Urgent Care co-pay	\$20	\$30	30%	\$10	\$20
Specialists/Consultants co-pay	\$20	\$30	30%	\$10	\$20
Prenatal, postnatal office visit co-pay	\$20	\$30	30%	\$0	
Scans: CT, CAT, MRI, PET etc.	0%	20%	30%	\$0	
Diagnostic X-ray & Laboratory Procedures	0%	20%	30%	\$0	
Infertility (Refer to Plan Document)	Not covered			Co-pay applies	
Preventive Care (includes physical exams & screenings)	0% Ded Waived			\$0	

HOSPITAL & SKILLED NURSING FACILITY SERVICES

Emergency Room visit (copay waived if admitted)	0% \$100 co-pay	20% \$100 co-pay	30% \$100 co-pay	\$100	
Inpatient Hospital (preauthorization required) - limits may apply	0%	20%	30%	\$0	
Outpatient Hospital	0%	20%	30%	\$10	\$20
Surgery, Outpatient (performed in Surgery Center)	0%	20%	30%	\$10	\$20
Surgery, Outpatient (performed in a Hospital) - limits may apply	0%	20%	30%	\$10	\$20

MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT

INPATIENT: Facility Based Care (preauth required)	0%	20%	30%	\$0	
OUTPATIENT: Facility Based Care (preauth required)	0%	20%	30%	\$10	\$20

OTHER SERVICES

Ambulance (Ground or Air)	0% \$100 co-pay	20% \$100 co-pay	30% \$100 co-pay	\$50	
Acupuncture - Limits apply	0% Uses ASH Network	20% Uses ASH Network	30% Uses ASH Network	\$10/30 visits (through ASH) combined w/chiro	
Chiropractic - Limits apply	0% Uses ASH Network	20% Uses ASH Network	30% Uses ASH Network	\$10/30 visits (through ASH) combined w/acu	
Durable Medical Equipment (DME)	0%	20%	30%	no charge	
Physical and Occupational Therapy - Limits apply	0%	20%	30%	\$10	\$20
Hearing Aids	Amount in excess of \$700 allowance/24 months	20% and Amount in excess of \$700 allowance/24 months	10% and Amount in excess of \$700 allowance/24 months	amount in excess of \$500 allowance every 36 months	

PHARMACY BENEFITS

Plan	5-20	200/10-35	5-20	9-35	Two-Tier HSA \$5000	Trad HMO \$10	Trad HMO \$20
Pharmacy Benefit Manager	Navitus					Kaiser	
Individual/Family Brand & Specialty Rx Deductibles	none	\$200/\$500	none		Included w/ Medical ded	none	
Individual/Family Rx Out-of-Pocket (OOP) Max <i>(includes Rx deductibles and co-pays)</i>	\$1,500/\$2,500	\$2,500/\$3,500	\$1,500/\$2,500	\$2,500/\$3,500	Included w/ Med OOP Max	Included w/ Med OOP Max	
Generic co-pay/30 days supply	\$0 at Costco \$5 at Other Network	\$0 at Costco \$10 at Other Network	\$0 at Costco \$5 at Other Network	\$0 at Costco \$9 at Other Network	Deductible, then \$0 at Costco or \$9 at Other Network	\$10	
Brand co-pay/30 days supply	\$20	\$35.00	\$20.00	\$35.00	Deductible, then \$35	\$10	\$20
Specialty co-pay/up to 30 days supply	\$20 Must Use Navitus Mail	\$35 Must Use Navitus Mail	\$20 Must Use Navitus Mail	\$35 Must Use Navitus Mail	Deductible, then \$35 (Must Use Navitus Mail)	\$10	\$20
Mail Order (Generic-Brand co-pay/90 days supply)	\$0-\$50	\$0-\$90	\$0-\$50	\$0-\$90	Deductible, then \$0 \$90	\$10 (100 days)	\$10-\$20 (100 days)
Mail Order Pharmacy	Costco Mail Order Pharmacy					Kaiser Mail Order Pharmacy	

This sheet is only a brief summary of In-Network patient costs. Please refer to the plan documents available through your district for applicable details, limitations, and exclusions. Out-of-Network services may not be covered. Employee cost/payroll deduction, if applicable, can be requested from the district.