CMSA 24/25

RETIRED CONFIDENTIAL, MANAGEMENT, SUPERVISORY & ADMINISTRATORS
$17,500 DISTRICT HEALTH BENEFITS CAP
2024 - 2025 HEALTH PLAN ELECTION FORM

To make your selection: Circle the rate of the premium for the selected plan, initial, sign, date and return to HR - Benefits.

Effective 10/01/2024

BENEFIT PLANS:	***Amount per Month for 12 Months*** **Retiree Premium Single:**	***Amount per Month for 12 Months*** **Retiree Premium 2-Party:**	***Amount per Month for 12 Months*** **Retiree Premium Family:**	**Initial:**
PPO PLAN PROVIDER - BLUE SHIELD				
0P021002 BS PPO 100%-A, $20 Co-pay, $0 Deductible, Rx $7-$25	$0.00	$557.22	$1,122.72	
0P041002 BS PPO 100%-C, $20 Co-pay, $200 Ind./$400 Fam. Deductible, Rx $200/$10-$35	$0.00	$447.22	$980.72	
0P011002 BS PPO 90%-C, $20 Co-pay, $200 Ind./$500 Fam. Deductible, Rx $9-$35	$0.00	$391.22	$910.72	
0P031002 BS PPO 80%-G, $30 Co-pay, $500 Ind./$1,000 Fam. Deductible, Rx $9-$35	$0.00	$175.22	$636.72	
0P071000 (High Deductible Health Plan - HSA 1700) Deductible then BS PPO 90% & Rx $9-$35, $1,700 Deductible if Single / $3,400 otherwise	$0.00	$0.00	$404.72	
HMO PLAN PROVIDER - KAISER				
234480-0027 / RMN Kaiser HMO w/ Chiro, $10 Co-Pay, $0 Deductible, Rx $10	$0.00	$103.22	$726.72	
234480-0029 / RMN Kaiser HMO w/ Chiro, $30 Co-Pay, $0 Deductible, Rx $10-$30	$0.00	$49.22	$649.72	
DENTAL PLAN PROVIDER - DELTA DENTAL				
7079 2390 DD PPO Incentive Plan- $2,000 max. per year, Ortho: Children Only (Life max $1,500)	INCLUDED IN MEDICAL PREMIUM			
VISION PLAN PROVIDER - VISION SERVICE PLAN				
2524/64253RMN VSP Plan C- $0 Co-pay, Exam, Frames & Lenses every year	INCLUDED IN MEDICAL PREMIUM			
LIFE INSURANCE PLAN PROVIDER - MUTUAL OF OMAHA LIFE INSURANCE				
G000AMP6-R003 MO $50,000 Emp. Term Group Life & AD&D	INCLUDED IN MEDICAL PREMIUM			

Retiree Printed Name: **Date of Birth:**

Retiree Signature (required): **Date:**

Retiree Address:

Phone Number: **Email:**

BENEFIT PAYMENTS: All benefit premiums are 12 months, from October - September. Please make checks/money orders payable to Antelope Valley College and submit payment to Human Resources by the first of each month.

PREMIUMS: All medical, dental, and vision plans are tiered (single, 2-party and family) rates.

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 RETIREES: Coverage begins the **first of the month following retirement date.**

RESIGNATION/TERMINATION/LACK OF PAYMENT/AGE OFF: Benefits stop on the **last day of the month the employee meets district qualifications.**

SISC
Self-Insured Schools of California
Schools Helping Schools

Antelope Valley Community College District

CMSA Retiree Plan Matrix for 2024/2025

	Blue Shield						Kaiser	
	100-A $20 0P021002	**100-C $20 0P041002**	**90-C $20 0P011002**	**80-G $30 0P031002**	**HSA $1700 Single 0P061002**	**HSA $1700 - Family 0P071002**	**Trad HMO $10 234480-0027/RMN**	**Trad HMO $30 234480-0029/RMN**
MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**						**Member Pays**	
Individual/Family Deductibles	$0/$0	$200/$400	$200/$500	$500/$1,000	$1,700	$3,400/$3,400	$0	
Individual/Family Out-of-Pocket (OOP) Max	$1,000/$3,000			$2,000/$4,000	$3,400	$3,400/$6,800	$1,500/$3,000	
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 10%		$10	$30
Urgent Care co-pay	$20			$30	10%		$10	$30
Specialists/Consultants co-pay	$20			$30	10%		$10	$30
Prenatal, postnatal office visit co-pay	$20			$30	10%		$0	
Scans: CT, CAT, MRI, PET etc.	0%		10%	20%	10%		$0	
Diagnostic X-ray & Laboratory Procedures	0%		10%	20%	10%		$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		10% $100 co-pay	20% $100 co-pay	10% $100 co-pay		$100	
Inpatient Hospital (preauthorization required)	0%		10%	20%	10%		$0	
Outpatient Hospital	0%		10%	20%	10%		$10	$30
Surgery, Outpatient (performed in Surgery Center)	0%		10%	20%	10%		$10	$30
Surgery, Outpatient (performed in a Hospital)	0%		10%	20%	10%		$10	$30
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT								
INPATIENT: Facility Based Care (preauth required)	0%		10%	20%	10%		$0	
OUTPATIENT: Facility Based Care (preauth req'd)	0%		10%	20%	10%		$10	$30
OTHER SERVICES								
Ambulance (Ground or Air)	0%, $100 co-pay		10%, $100 co-pay	20%, $100 co-pay	10%, $100 co-pay		$50	
Acupuncture - Limits apply	0%		10%	20%	10%		$10/30 visits ASH	
Chiropractic - Limits apply	0%		10%	20%	10%		$10/30 visits ASH	
Durable Medical Equipment (DME)	0%		10%	20%	10%		no charge	
Physical and Occupational Therapy - Limits	0%		10%	20%	10%		$10	$30
Hearing Aids Every 24 months on PPO, 36 months HMO)	Amount in excess of $700		10% + Amount in excess of $700	20% + Amount in excess of $700	10% + Amount in excess of $700		Amount in excess of $500	
PHARMACY BENEFITS								
Plan	**7-25**	**200/10-35**	**9-35**	**9-35**	**HSA Rx**		**Trad HMO $10**	**Trad HMO $10-30**
Pharmacy Benefit Manager	Navitus						Kaiser	
Indiv./Family Brand & Specialty Rx Deductibles	$0	$200/$500	$0		Included w/ Medical ded		$0	
Individual/Family Rx Out-of-Pocket (OOP) Max	$1,500/$2,500	$2,500/$3,500	$2,500/$3,500		Included w/ Med OOP Max		Included w/ Med OOP Max	
Generic co-pay/30 days supply	$0 at Costco $7 Elsewhere	$0 at Costco $10 Eslewhere	$0 at Costco $9 at Other Network		Deductible, then $0 at Costco $9 Elsewhere		$10	
Brand co-pay/30 days supply	$25	$35.00	$35.00		Deductible, then $35		$10	$30
Specialty co-pay/up to 30 days supply	$25 Must Use Navitus Mail	$35 Must Use Navitus Mail	$35 Must Use Navitus Mail		Deductible, then $35 (Must Use Navitus Mail)		$10	$30
Mail Order (Generic-Brand co-pay/90 days)	$0-$60	$0-$90	$0-$90		Deductible, then $18-$90		$10 (100 days)	$20-$60 (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.