CMSA
24/25

ANTELOPE VALLEY COLLEGE

CONFIDENTIAL, MANAGEMENT, SUPERVISORY & ADMINISTRATORS

$17,500 DISTRICT HEALTH BENEFITS CAP

2024 - 2025 HEALTH PLAN ELECTION FORM

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

Effective 10/01/2024

BENEFIT PLANS:	*Amount per Month for 12 Months* Pre-Tax Employee Premium Deduction:	Selection
PPO PLAN PROVIDER - BLUE SHIELD		
0P021000 BS PPO 100%-A, $20 Co-pay, $0 Deductible, Rx $7-$25	$550.42	
0P041000 BS PPO 100%-C, $20 Co-pay, $200 Ind./$400 Fam. Deductible, Rx $200/$10-$35	$438.42	
0P011000 BS PPO 90%-C, $20 Co-pay, $200 Ind./$500 Fam. Deductible, Rx $9-$35	$383.42	
0P031000 BS PPO 80%-G, $30 Co-pay, $500 Ind./$1,000 Fam. Deductible, Rx $9-$35	$167.42	
0P071000 (High Deductible Health Plan - HSA 1700) Deductible then BS PPO 90% & Rx $9-$35, $1,700 Deductible if Single / $3,400 Deductible otherwise	$0.00	
0P051001- (HDHP - HSA 5000 - *SPOUSE INELIGIBLE*) Deductible then BS 70% & Rx $9-$35, $5,000 Ind./$10,000 Fam. Deductible	$0.00 NO DENTAL/VISION COVERAGE	
WAIVER of Active Benefits Enrollment - WABE64253M Access Only to EAP, Teladoc (Expert Medical Opinion), MDLive, & Health Smarts	$0.00 NO MEDICAL/DENTAL/VISION	
HMO PLAN PROVIDER - KAISER		
234480-0027 / AMN Kaiser HMO w/ Chiro, $10 Co-Pay, $0 Deductible, Rx $10	$173.42	
234480-0029 / AMN Kaiser HMO w/ Chiro, $30 Co-Pay, $0 Deductible, Rx $10-$30	$115.42	
DENTAL PLAN PROVIDER - DELTA DENTAL		
7079 1390 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		
2524/64253AMN 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-A001 MO $50,000 Emp. Term Group Life & AD&D, Decreases at age 65	INCLUDED IN MEDICAL PREMIUM	

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-taxed unless 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, from October - September

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**.

SISC
Self-Insured Schools of California
Schools Helping Schools

Antelope Valley Community College District

CMSA Plan Matrix for 2024/2025

	Blue Shield							Kaiser	
	100-A $20 0P021000	**100-C $20 0p041000**	**90-C $20 0P011000**	**80-G $30 0P031000**	**HSA $1700 Single 0P061000**	**HSA $1700 - Family 0P071000**	**Two-Tier HSA $5000 0P051001**	**Trad HMO $10 234480-0027/AMN**	**Trad HMO $30 234480-0029/AMN**
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	$5,000/$10,000	$0	
Individual/Family Out-of-Pocket (OOP) Max	$1,000/$3,000			$2,000/$4,000	$3,400	$3,400/$6,800	$6,350/$12,700	$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%		Deductible, then 30%	$10	$30
Urgent Care co-pay	$20			$30	10%		30%	$10	$30
Specialists/Consultants co-pay	$20			$30	10%		30%	$10	$30
Prenatal, postnatal office visit co-pay	$20			$30	10%		30%	$0	
Scans: CT, CAT, MRI, PET etc.	0%		10%	20%	10%		30%	$0	
Diagnostic X-ray & Laboratory Procedures	0%		10%	20%	10%		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		10% $100 co-pay	20% $100 co-pay	10% $100 co-pay		30% $100 co-pay	$100	
Inpatient Hospital (preauthorization required)	0%		10%	20%	10%		30%	$0	
Outpatient Hospital	0%		10%	20%	10%		30%	$10	$30
Surgery, Outpatient (performed in Surgery Center)	0%		10%	20%	10%		30%	$10	$30
Surgery, Outpatient (performed in a Hospital)	0%		10%	20%	10%		30%	$10	$30
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT									
INPATIENT: Facility Based Care (preauth required)	0%		10%	20%	10%		30%	$0	
OUTPATIENT: Facility Based Care (preauth req'd)	0%		10%	20%	10%		30%	$10	$30
OTHER SERVICES									
Ambulance (Ground or Air)	0%, $100 co-pay		10%, $100 co-pay	20%, $100 co-pay	10%, $100 co-pay		30%, $100 co-pay	$50	
Acupuncture - Limits apply	0%		10%	20%	10%		30%, ASH	$10/30 visits ASH	
Chiropractic - Limits apply	0%		10%	20%	10%		30%, ASH	$10/30 visits ASH	
Durable Medical Equipment (DME)	0%		10%	20%	10%		30%	no charge	
Physical and Occupational Therapy - Limits	0%		10%	20%	10%		30%	$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		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**		**HSA $5000**	**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.