Retired CL
$17,500
24/25

ANTELOPE VALLEY COLLEGE

CLASSIFIED RETIREES
$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 - Anthem Blue Cross				
40011L BC PPO 100%-A, $20 Co-pay, $0 Deductible, Rx $7-$25	**$0.00**	**$561.42**	**$1,129.02**	
40011M BC PPO 100%-B, $20 Co-pay, $100 Ind./$300 Fam. Deductible, Rx $9-$35	**$0.00**	**$501.42**	**$1,052.02**	
40011N BC PPO 90%-A, $20 Co-pay, $100 Ind./$300 Fam. Deductible, Rx $9-$35	**$0.00**	**$442.42**	**$977.02**	
40011Q BC PPO 80%-G, $30 Co-pay, $500 Ind./$1,000 Fam. Deductible, Rx $9-$35	**$0.00**	**$179.42**	**$643.02**	
HMO PLAN PROVIDER - Kaiser Permanente				
234480-0027 / RLN Kaiser HMO w/ Chiro, $10 Co-Pay, $0 Deductible, Rx $10	**$0.00**	**$107.42**	**$733.02**	
234480-0028 / RLN Kaiser HMO w/ Chiro, $20 Co-Pay, $0 Deductible, Rx $10-$20	**$0.00**	**$77.42**	**$691.02**	
DENTAL PLAN PROVIDER - Delta Dental				
7079 2290 DD PPO Incentive Plan- $2,000 max. per year, Ortho: Children Only (Life max $1,500)	INCLUDED IN MEDICAL PREMIUM			
VISION PLAN PROVIDER - VSP				
2523/64253ALN VSP Signature Plan C, $0 Co-pay, 2nd Pair	INCLUDED IN MEDICAL PREMIUM			
LIFE INSURANCE PLAN PROVIDER - Mutual of Omaha				
G000AMP6-R003 MO $50,000 Emp. Term Group Life & AD&D	INCLUDED IN MEDICAL PREMIUM			

BENEFIT PAYMENT AUTHORIZATION: I understand that the monthly retiree premium applicable to the plan I have selected is due the 1st of each month, and that if the premium payments are not made in a timely manner my insurance coverage may be terminated.

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

Classified Retiree Plan Matrix for 2024/2025

	Anthem				Kaiser	
	100-A $20 40011L	**100-B $20 40011M**	**90-A $20 40011N**	**80-G $30 40011Q**	**Trad HMO $10 234480-0027/RLN**	**Trad HMO $20 234480-0028/RLN**
MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**				**Member Pays**	
Individual/Family Deductibles	$0/$0	$100/$300		$500/$1,000	$0	
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	$1,000/$3,000			$2,000/$4,000	$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	$10	$20
Urgent Care co-pay	$20			$30	$10	$20
Specialists/Consultants co-pay	$20			$30	$10	$20
Prenatal, postnatal office visit co-pay	$20			$30	$0	
Scans: CT, CAT, MRI, PET etc.	0%		10%	20%	$0	
Diagnostic X-ray & Laboratory Procedures	0%		10%	20%	$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	$100	
Inpatient Hospital (preauthorization required) - limits may apply	0%		10%	20%	$0	
Outpatient Hospital	0%		10%	20%	$10	$20
Surgery, Outpatient (performed in Surgery Center)	0%		10%	20%	$10	$20
Surgery, Outpatient (performed in a Hospital) - limits may apply	0%		10%	20%	$10	$20
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT						
INPATIENT: Facility Based Care (preauth required)	0%		10%	20%	$0	
OUTPATIENT: Facility Based Care (preauth required)	0%		10%	20%	$10	$20
OTHER SERVICES						
Ambulance (Ground or Air)	0% $100 co-pay		10% $100 co-pay	20% $100 co-pay	$50	
Acupuncture - Limits apply	0% Uses ASH Network		10% Uses ASH Network	20% Uses ASH Network	$10/30 visits (through ASH) combined w/chiro	
Chiropractic - Limits apply	0% Uses ASH Network		10% Uses ASH Network	20% Uses ASH Network	$10/30 visits (through ASH) combined w/acu	
Durable Medical Equipment (DME)	0%		10%	20%	no charge	
Physical and Occupational Therapy - Limits apply	0%		10%	20%	$10	$20
Hearing Aids	Amount in excess of $700 allowance/24 months		10% and Amount in excess of $700 allowance/24 months	20% and Amount in excess of $700 allowance/24 months	amount in excess of $500 allowance every 36 months	
PHARMACY BENEFITS						
Plan	**7-25**	**9-35**	**9-35**	**9-35**	**Trad HMO $10**	**Trad HMO $20**
Pharmacy Benefit Manager	Navitus				Kaiser	
Individual/Family Brand & Specialty Rx Deductibles	none				none	
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	$1,500/$2,500	$2,500/$3,500			Included w/ Med OOP Max	
Generic co-pay/30 days supply	$0 at Costco $7 at Other Network	$0 at Costco $9 at Other Network			$10	
Brand co-pay/30 days supply	$25	$35.00			$10	$20
Specialty co-pay/up to 30 days supply	$25 Must Use Navitus Mail	$35 Must Use Navitus Mail			$10	$20
Mail Order (Generic-Brand co-pay/90 days supply)	$0-$60	$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.