



**AVCFT: FACULTY 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				Amount per Month for 12 Months			
	Retiree Premium	Retiree Premium	Retiree Premium	Initial:	Retiree Premium	Retiree Premium	Retiree Premium	Initial:
	Single:	2-Party:	Family:		Single:	2-Party:	Family:	
<b>PPO PLAN PROVIDER - ANTHEM BLUE CROSS</b>								
	<i>With Dental Plan 1 (PPO Incentive)</i>							
	<i>With Dental Plan 2 (PPO)</i>							
<b>40463K</b> BC PPO 100%-A, \$20 Co-pay, \$0 Deductible, Rx \$5-\$20	\$0.00	\$586.82	\$1,162.42		\$0.00	\$559.22	\$1,115.12	
<b>40463L</b> BC PPO 100%-B, \$20 Co-pay, \$100 Ind./\$300 Fam. Deductible, Rx \$200/\$10-\$35	\$0.00	\$471.82	\$1,015.42		\$0.00	\$444.22	\$968.12	
<b>40463M</b> BC PPO 80%-C, \$20 Co-pay \$200 Ind./\$500 Fam. Deductible, Rx \$5-\$20,	\$0.00	\$386.82	\$908.42		\$0.00	\$359.22	\$861.12	
<b>40463N</b> BC PPO 80%-K, \$30 Co-pay, \$1,000 Ind./\$2,000 Fam. Deductible, Rx \$9-\$35	\$0.00	\$125.82	\$576.42		\$0.00	\$98.22	\$529.12	
<b>HMO PLAN PROVIDER - KAISER PERMANENTE</b>								
<b>234480-0027 / RCN</b> Kaiser HMO w/ Chiro, \$10 Co-Pay, \$0 Deductible, Rx \$10	\$0.00	\$189.82	\$651.42		\$0.00	\$162.22	\$604.12	
<b>234480-0028 / RCN</b> Kaiser HMO w/ Chiro, \$20 Co-Pay, \$0 Deductible, Rx \$10-\$20	\$0.00	\$157.82	\$611.42		\$0.00	\$130.22	\$564.12	
<b>DENTAL PLAN PROVIDER - DELTA DENTAL</b>								
<b>7079 2300 (DENTAL PLAN 1)</b> DD PPO Incentive Plan- \$2,000 max. per year, 3rd Cleaning, Ortho: Adults & Children \$1,500 lifetime	INCLUDED IN MEDICAL PREMIUM							
<b>7079 2350 (DENTAL PLAN 2)</b> DD PPO Plan- \$1,500 max. per year					INCLUDED IN MEDICAL PREMIUM			
<b>VISION PLAN PROVIDER - VISION SERVICE PLAN</b>								
<b>2536/64253RCN</b> VSP Signature Plan C- \$5 Co-pay, 2nd Pair					INCLUDED IN MEDICAL PREMIUM			
<b>LIFE INSURANCE PLAN PROVIDER - MUTUAL OF OMAHA LIFE INSURANCE</b>								
<b>G000AMP6-R003</b> MO \$50,000 Emp. Term Group Life & AD&D					INCLUDED IN MEDICAL PREMIUM			

253664253ACN

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.



**Antelope Valley Community College District**

**Retired Faculty Plan Matrix for 2024/2025**

	Anthem				Kaiser	
	100-A \$20 40463K	100-B \$20 40463L	80-C \$20 40463M	80-K \$30 40463N	Trad HMO \$10 234480-0027/RCN	Trad HMO \$20 234480-0028/RCN
MEDICAL - CALENDAR YEAR Deductibles & Maximums	<b>Member Pays</b>				<b>Member Pays</b>	
Individual/Family Deductibles	\$0/\$0	\$100/\$300	\$200/\$500	\$1,000/\$2,000	\$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	\$1,500/\$3,000	

**PROFESSIONAL SERVICES**

Office Visit (OV) co-pay <i>(\$0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)</i>	\$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%		20%	\$0	
Diagnostic X-ray & Laboratory Procedures	0%		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 <i>(copay waived if admitted)</i>	0% \$100 co-pay	20% \$100 co-pay	\$100	
Inpatient Hospital (preauthorization required) - limits may apply	0%	20%	\$0	
Outpatient Hospital	0%	20%	\$10	\$20
Surgery, Outpatient (performed in Surgery Center)	0%	20%	\$10	\$20
Surgery, Outpatient (performed in a Hospital) - limits may apply	0%	20%	\$10	\$20

**MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT**

<b>INPATIENT:</b> Facility Based Care (preauth required)	0%	20%	\$0	
<b>OUTPATIENT:</b> Facility Based Care (preauth required)	0%	20%	\$10	\$20

**OTHER SERVICES**

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

**PHARMACY BENEFITS**

Plan	5-20	200/10-35	5-20	9-35	Trad HMO \$10	Trad HMO \$20
Pharmacy Benefit Manager	Navitus				Kaiser	
Individual/Family Brand & Specialty Rx Deductibles	none	\$200/\$500	none		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	
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	\$10	
Brand co-pay/30 days supply	\$20	\$35.00	\$20.00	\$35.00	\$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	\$10	\$20
Mail Order (Generic-Brand co-pay/90 days supply)	\$0-\$50	\$0-\$90	\$0-\$50	\$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.