ANTELOPE VALLEY COLLEGE

AVCFT: REGULAR FACULTY EMPLOYEES

$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	Selection	*Amount per Month for 12 Months* Pre-Tax Employee Premium	Selection
PPO PLAN PROVIDER - ANTHEM BLUE CROSS	***With Dental Plan 1***		***With Dental Plan 2***	
40463A BC PPO 100%-A, $20 Co-pay, $0 Deductible, Rx $5-$20	$580.52	☐	$547.62	☐
40463B BC PPO 100%-B, $20 Co-pay, $100 Ind./$300 Fam. Deductible, Rx $200/$10-$35	$462.52	☐	$429.62	☐
40463C BC PPO 80%-C, $20 Co-pay, $200 Ind./$500 Fam. Deductible, Rx $5-$20	$380.52	☐	$347.62	☐
40463D BC PPO 80%-K, $30 Co-pay, $1,000 Ind./$2,000 Fam. Deductible, Rx $9-$35	$117.52	☐	$84.62	☐
70112B (HSA 5000 - *SPOUSE INELIGIBLE*) Deductible then BC 70% & Rx $9-$35, $5,000 Ind./$10,000 Fam. Deductible	$0.00 NO DENTAL/VISION COVERAGE	☐	$0.00 NO DENTAL/VISION COVERAGE	☐
WAIVER of Active Benefits Enrollment - WABE64253C Access Only to EAP, Teladoc (Expert Medical Opinion), MDLive, & Health Smarts	$0.00 NO MEDICAL/DENTAL/VISION	☐	$0.00 NO MEDICAL/DENTAL/VISION	☐
HMO PLAN PROVIDER - KAISER PERMANENTE				
234480-0027 / ACN Kaiser HMO w/ Chiro, $10 Co-Pay, $0 Deductible, Rx $10	$180.52	☐	$147.62	☐
234480-0028 / ACN Kaiser HMO w/ Chiro, $20 Co-Pay, $0 Deductible, Rx $10-$20	$148.52	☐	$115.62	☐
DENTAL PLAN PROVIDER - DELTA DENTAL				
7079 1300 (DENTAL PLAN 1) DD PPO Incentive Plan- $2,000 max. per year, 3rd cleaning, Ortho: Adults and Children (Lifetime max $1,500)	INCLUDED IN MEDICAL PREMIUM			
7079 1350 (DENTAL PLAN 2) DD PPO Plan- $1,500 max. per year			INCLUDED IN MEDICAL PREMIUM	
VISION PLAN PROVIDER - VISION SERVICE PLAN				
2536/64253ACN VSP Signature Plan C- $5 Co-pay, 2nd Pair	INCLUDED IN MEDICAL PREMIUM			
LIFE INSURANCE PLAN PROVIDER - MUTUAL OF OMAHA LIFE INSURANCE				
G000AMP6-A002 MO $50,000 Emp. Term Group Life & AD&D, Decreases at age 70	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
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 (includes medical deductibles, co-insurance and co-pays)	$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	

	Anthem					Kaiser	
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 (includes Rx deductibles and co-pays)	$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.