



**Antelope Valley Community College District
2023/2024 Classified Plan Matrix**

	Anthem 40011A	Anthem 40011B	Anthem 40011C	Anthem 40011E	Anthem 70111B	Kaiser 234480-0027ACN	Kaiser 234480-0028ACN
	100-A \$20	100-B \$20	90-A \$20	80-G \$30	Two-Tier HSA \$5000	Trad HMO \$10	Trad HMO \$20
MEDICAL - CALENDAR YEAR Deductibles & Maximums	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Individual/Family Deductibles	\$0/\$0	\$100/\$300	\$100/\$300	\$500/\$1,000	\$5,000/\$10,000*	0	0
Individual/Family Out-of-Pocket (OOP) Max <i>(includes medical deductibles, co-insurance and co-pays)</i>	\$1,000/\$3,000	\$1,000/\$3,000	\$1,000/\$3,000	\$2,000/\$4,000	\$6,350/\$12,700*	\$1,500/\$3,000	\$1,500/\$3,000

*Includes Rx

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	\$20	\$20	\$30	Deductible, then 30%	\$10	\$20
Urgent Care co-pay	\$20	\$20	\$20	\$30	30%	\$10	\$20
Specialists/Consultants co-pay	\$20	\$20	\$20	\$30	30%	\$10	\$20
Prenatal, postnatal office visit co-pay	\$20	\$20	\$20	\$30	30%	\$0	\$0
Scans: CT, CAT, MRI, PET etc.	0%	0%	10%	20%	30%	\$0	\$0
Diagnostic X-ray & Laboratory Procedures	0%	0%	10%	20%	30%	\$0	\$0
Infertility (diagnosis/treatment of causes of infertility subject to plan benefits)	Not covered	Not covered	Not covered	Not covered	Not covered	Co-pay applies	Co-pay applies
Preventive Care (includes physical exams & screenings)	0% Ded Waived	0% Ded Waived	0% Ded Waived	0% Ded Waived	0% Ded Waived	\$0	\$0

HOSPITAL & SKILLED NURSING FACILITY SERVICES

Emergency Room visit (waived if admitted)	0% \$100 co-pay	0% \$100 co-pay	10% \$100 co-pay	20% \$100 co-pay	30% \$100 co-pay	\$100	\$100
Inpatient Hospital (pre-auth required) - limits may apply	0%	0%	10%	20%	30%	\$0	\$0
Outpatient Hospital	0%	0%	10%	20%	30%	\$10	\$20
Surgery, Outpatient (performed in Surgery Center)	0%	0%	10%	20%	30%	\$10	\$20
Surgery, Outpatient (in a Hospital) - limits may apply	0%	0%	10%	20%	30%	\$10	\$20

MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT

INPATIENT: Facility Based Care (preauth required)	0%	0%	10%	20%	30%	\$0	\$0
OUTPATIENT: Facility Based Care (preauth required)	0%	0%	10%	20%	30%	\$10	\$20

OTHER SERVICES

Acupuncture - Limits apply, all plans use ASH Network	0%	0%	10%	20%	30%	\$10/30 visits*	\$10/30 visits*
Ambulance (Ground or Air)	0% \$100 co-pay	0% \$100 co-pay	10% \$100 co-pay	20% \$100 co-pay	30% \$100 co-pay	\$50	\$50
Chiropractic - Limits apply, all plans use ASH Network	0%	0%	10%	20%	30%	\$10/30 visits*	\$10/30 visits*
Durable Medical Equipment (DME)	0%	0%	10%	20%	30%	no charge	no charge
Physical and Occupational Therapy - Limits apply	0%	0%	10%	20%	30%	\$10	\$20
Hearing Aids	Amount in excess of \$700 allowance/24 months	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	10% and Amount in excess of \$700 allowance/24 months	Amount in excess of \$500 allowance every 36 months	Amount in excess of \$500 allowance every 36 months

*30 visits Chiro/Acu combined sits Chiro/Acu combined

PHARMACY BENEFITS

Plan	7-25	9-35	9-35	9-35	Anchor Bronze Rx	Trad HMO \$10	Trad HMO \$20
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Navitus	Navitus	Kaiser	Kaiser
Individual/Family Brand & Specialty Rx Deductibles	none	none	none	none	Included w/ Medical ded	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	\$2,500/\$3,500	\$2,500/\$3,500	Included w/ Med OOP Max	Included w/ Med OOP Max	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	\$0 at Costco \$9 at Other Network	\$0 at Costco \$9 at Other Network	Deductible, then \$0 at Costco or \$9 Elsewhere	\$10 up to 100 day supply	\$10 up to 100 day supply
Brand co-pay/30 days supply	25	35	35	35	Deductible, then \$35	\$10 up to 100 day supply	\$20 up to 100 day supply
Specialty co-pay/up to 30 days supply	\$25 Must Use Navitus Mail	\$35 Must Use Navitus Mail	\$35 Must Use Navitus Mail	\$35 Must Use Navitus Mail	Deductible, then \$35 (Must Use Navitus Mail)	\$10 up to 30 day supply	\$20 up to 30 day supply
Mail Order (Generic-Brand co-pay/90 days supply)	\$0-\$60	\$0-\$90	\$0-\$90	\$0-\$90	Deductible, then \$0-\$90	\$10-\$10/up to 100 day supply	\$10-\$20/up to 100 day supply
Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Kaiser 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.