SISC
Self-Insured Schools of California
Schools Helping Schools

Antelope Valley College
Classified Plans

2025-2026	Anthem	Anthem	Anthem	Anthem	Anthem	Anthem	Kaiser	Kaiser
	100-A $20	100-B $20	90-A $20	80-G $30	2-Tier HSA $5,000	Platinum+	$10 OV, $10 Rx	$20 OV, $10-20 Rx
MEDICAL - CALENDAR YEAR Deductibles & Maximums	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays
Individual/Family Deductibles (Ded)	$0/$0	$100/$300	$100/$300	$500/$1,000	$5,000/$10,000*	$0/$0	$0	$0
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	$1,000/$3,000	$1,000/$3,000	$1,000/$3,000	$2,000/$4,000	$6,350/$12,700*	$1,000/$3,000	$1,500/$3,000	$1,500/$3,000
					*Includes Rx			
PROFESSIONAL SERVICES								
Primary Care* visit co-pay ($0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)	$20	$20	$20	$30	Deductible, then 30% after Ded	$0	$10	$20
Urgent Care co-pay	$20	$20	$20	$30	30% after Ded	$0	$10	$20
Prenatal, postnatal office visit co-pay	$20	$20	$20	$30	30% after Ded	$0	$0	$0
Specialists/Consultants co-pay	$20	$20	$20	$30	30% after Ded	$40	$10	$20
						Non-Hosp/OPH**		
Scans: CT, CAT, MRI, PET etc.	0% after Ded	0% after Ded	10% after Ded	20% after Ded	30% after Ded	$100/$250	$0	$0
Laboratory Procedures	0% after Ded	0% after Ded	10% after Ded	20% after Ded	30% after Ded	$0/$50	$0	$0
Diagnostic X-rays	0% after Ded	0% after Ded	10% after Ded	20% after Ded	30% after Ded	$25/$75	$0	$0
Infertility (Refer to Plan Document)	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Co-pay applies	Co-pay applies
Preventive Care (includes physical exams & screenings)	0% after Ded Ded Waived	0% after Ded Ded Waived	0% after Ded Ded Waived	0% after Ded Ded Waived	0% after Ded Ded Waived	$0	$0	$0
HOSPITAL & SKILLED NURSING FACILITY SERVICES								
Emergency Room visit (copay waived if admitted) - **Avg Cost: $2,847 | $100+10%: $375 | $100+20%: $649**	0% after Ded $100 co-pay	0% after Ded $100 co-pay	10% after Ded $100 co-pay	20% after Ded $100 co-pay	30% after Ded $100 co-pay	$300	$100	$100
Inpatient Hospital (preauthorization required) - **Avg Cost for one day: $6,067 | 10%: $607 | 20%: $1,213**	0% after Ded	0% after Ded	10% after Ded	20% after Ded	30% after Ded	$200/day	$0	$0
Surgery, Outpatient (performed in Surgery Center)	0% after Ded	0% after Ded	10% after Ded	20% after Ded	30% after Ded	$200	$10	$20
Surgery, Outpatient (performed in a Hospital) - limits may apply	0% after Ded	0% after Ded	10% after Ded	20% after Ded	30% after Ded	$600	$10	$20
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT								
INPATIENT: Facility Based Care (preauth required)	0% after Ded	0% after Ded	10% after Ded	20% after Ded	30% after Ded	$200/day	$0	$0
OUTPATIENT: Facility Based Care (preauth required)	0% after Ded	0% after Ded	10% after Ded	20% after Ded	30% after Ded	$0	$10	$20
OTHER SERVICES								
Ambulance (Ground or Air)	0% after Ded $100 co-pay	0% after Ded $100 co-pay	10% after Ded $100 co-pay	20% after Ded $100 co-pay	30% after Ded $100 co-pay	$300	$50	$50
Acupuncture - Limits apply	0% after Ded Subject to PA	0% after Ded Subject to PA	10% after Ded Subject to PA	20% after Ded Subject to PA	30% after Ded Subject to PA	$0	$10/30 visits (through ASH) combined w/chiro	$10/30 visits (through ASH) combined w/chiro
Chiropractic - Limits apply	0% after Ded Subject to PA	0% after Ded Subject to PA	10% after Ded Subject to PA	20% after Ded Subject to PA	30% after Ded Subject to PA	$0	$10/30 visits (through ASH) combined w/acu	$10/30 visits (through ASH) combined w/acu
Physical and Occupational Therapy - Limits apply	0% after Ded	0% after Ded	10% after Ded	20% after Ded	30% after Ded	$0	$10	$20
Durable Medical Equipment (DME)	0% after Ded	0% after Ded	10% after Ded	20% after Ded	30% after Ded	$0	no charge	no charge
Hearing Aids	Amount in excess of $700 allowance/24 months	Amount in excess of $700 allowance/24 months	10% after Ded and Amount in excess of $700 allowance/24 months	20% after Ded and Amount in excess of $700 allowance/24 months	10% after Ded and Amount in excess of $700 allowance/24 months	$0 plus the 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

*Primary Care Providers (PCPs) are those without specialty certifications, practicing general pediatrics, internal medicine, family or general practice, or obstetrics and gynecology.

**"non-Hosp" means Labs and Radiology Centers not associated with a hospital system. "OPH" means an outpatient hospital setting

PHARMACY BENEFITS

Plan	Rx 7-25	Rx 9-35	Rx 9-35	Rx 9-35	Rx HSA	Rx 9-35 PC	$10 Rx	$10-20 Rx
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus	Kaiser	Kaiser
Individual/Family Brand & Specialty Rx Deductibles	none	none	none	none	Included w/ Medical ded	none	none	none
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	$1,500/$2,500	$2,500/$3,500	$2,500/$3,500	$2,500/$3,500	Included w/ Med OOP Max	$2,500/$3,500	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 at Other Network	$0 at Costco‡ $9 at Other Network	$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	$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)	$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	$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	Costco Mail Order Pharmacy	Kaiser Mail Order Pharmacy	Kaiser Mail Order Pharmacy

This comparison displays member cost-share for In-Network services. Out-of-Network services may not be covered. Please refer to the plan documents available through your district for applicable details, limitations, and exclusions. Employee cost/payroll deduction, if applicable, can be requested from the district.

‡Some narcotic pain and cough medications are not included in the Costco Free Generic or 90-day supply programs.