ANTELOPE VALLEY COLLEGE

CONFIDENTIAL, MANAGEMENT, SUPERVISORY & ADMINISTRATORS

$17,500 DISTRICT HEALTH BENEFITS CAP

2025 - 2026 HEALTH PLAN ELECTION FORM

To make your selection: Check the box next to your selected plan, sign, date and return to Benefits.

Effective 10/01/2025

BENEFIT PLANS:	*Amount per Month for 12 Months* Pre-Tax Employee Premium:	Selection
PPO COST SHARING PLANS - BLUE SHIELD of CA		
0P021000 100%-A, $20 Co-pay, $0 Deductible, Rx $7-$25	$671.42	
0P041000 100%-C, $20 Co-pay, $200 Ind./$400 Fam. Deductible, Rx $200/$10-$35	$556.42	
0P011000 90%-C, $20 Co-pay, $200 Ind./$500 Fam. Deductible, Rx $9-$35	$496.42	
0P031000 80%-G, $30 Co-pay, $500 Ind./$1,000 Fam. Deductible, Rx $200/$10-$35	$233.42	
0P071000 (HSA 1700) Deductible then 90% & Rx $9-$35, $1,700 Deductible if Single / $3,400 Deductible otherwise	$73.42	
0P051001 (HSA 5000 - *SPOUSE INELIGIBLE*) Deductible then 70% & Rx $9-$35, $5,000 Ind./$10,000 Fam. Deductible	$0.00 **NO DENTAL/VISION COVERAGE**	
PPO CO-PAY PLAN - ANTHEM BLUE CROSS		
M215 Platinum+ Primary Care Plan, $0 Co-pay (**ADD'L CO-PAYS FOR SOME SERVICES**), $0 Deductible, Rx $9-$35	$496.42	
HMO PLAN - KAISER PERMANENTE		
234480-0027 / AMN $10 Co-Pay, $0 Deductible, Rx $10 (100 days)	$263.42	
234480-0029 / AMN $30 Co-Pay, $0 Deductible, Rx $10-$30 (30 days)	$177.42	
DENTAL PLAN PROVIDER - DELTA DENTAL		
7079 1390 PPO Incentive Plan- $2,000 max. per year; Ortho: Children Only (Life max $1,500)	INCLUDED IN MEDICAL PREMIUM	
VISION PLAN PROVIDER - VSP		
2524 / 64253AMN Signature Plan C- $0 Co-pay, Exam, Frames & Lenses every year	INCLUDED IN MEDICAL PREMIUM	
LIFE INSURANCE PLAN PROVIDER - MUTUAL of OMAHA LIFE INSURANCE		
G000AMP6-A001 $50,000 Emp. Term Group Life & AD&D, Decreases at age 65	INCLUDED IN MEDICAL PREMIUM	
WAIVER of Active Benefits Enrollment		
WABE64253M Access Only to EAP, Teladoc, MDLive, Vida Health & Biometric Screenings	$0.00 **LIFE INSURANCE ONLY**	

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-tax unless otherwise requested. If post-tax option is requested you must meet with Benefits to complete required documents.

Employee Printed Name: **SSN or Employee 900#:**

Employee Signature (required): **Date:**

Phone Number or 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 College
CMSA Plans

2025-2026	Blue Shield	Blue Shield	Blue Shield	Blue Shield	Blue Shield	Blue Shield	Anthem	Kaiser	Kaiser
	100-A $20	100-C $20	90-C $20	80-G $30	HSA $1,700 FAM	2-Tier HSA $5,000	Platinum+	$10 OV, $10 Rx	$30 OV, $10-30 Rx
MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles (Ded)	$0/$0	$200/$400	$200/$500	$500/$1,000	$3,400/$3,400*	$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	$3,400/$6,800*	$6,350/$12,700*	$1,000/$3,000	$1,500/$3,000	$1,500/$3,000
					*Includes Rx	*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 10% after Ded	Deductible, then 30% after Ded	$0	$10	$30
Urgent Care co-pay	$20	$20	$20	$30	10% after Ded	30% after Ded	$0	$10	$30
Prenatal, postnatal office visit co-pay	$20	$20	$20	$30	10% after Ded	30% after Ded	$0	$0	$0
Specialists/Consultants co-pay	$20	$20	$20	$30	10% after Ded	30% after Ded	$40	$10	$30
							Non-Hosp/OPH**		
Scans: CT, CAT, MRI, PET etc.	0% after Ded	0% after Ded	10% after Ded	20% after Ded	10% after Ded	30% after Ded	$100/$250	$0	$0
Laboratory Procedures	0% after Ded	0% after Ded	10% after Ded	20% after Ded	10% after Ded	30% after Ded	$0/$50	$0	$0
Diagnostic X-rays	0% after Ded	0% after Ded	10% after Ded	20% after Ded	10% 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	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% 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	10% 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	10% 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	10% after Ded	30% after Ded	$200	$10	$30
Surgery, Outpatient (performed in a Hospital) - limits may apply	0% after Ded	0% after Ded	10% after Ded	20% after Ded	10% after Ded	30% after Ded	$600	$10	$30
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT									
INPATIENT: Facility Based Care (preauth required)	0% after Ded	0% after Ded	10% after Ded	20% after Ded	10% 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	10% after Ded	30% after Ded	$0	$10	$30
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	10% after Ded $100 co-pay	30% after Ded $100 co-pay	$300	$50	$50
Acupuncture - Limits apply	0% after Ded	0% after Ded	10% after Ded	20% after Ded	10% after Ded Uses ASH Network	30% after Ded	$0	$10/30 visits (through ASH) combined	$10/30 visits (through ASH) combined
Chiropractic - Limits apply	0% after Ded	0% after Ded	10% after Ded	20% after Ded	10% after Ded Uses ASH Network	30% after Ded	$0		
Physical and Occupational Therapy - Limits apply	0% after Ded	0% after Ded	10% after Ded	20% after Ded	10% after Ded	30% after Ded	$0	$10	$30
Durable Medical Equipment (DME)	0% after Ded	0% after Ded	10% after Ded	20% after Ded	10% 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	30% 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 200/10-35	Rx 9-35	Rx 200/10-35	Rx HSA	Rx HSA	Rx 9-35 PC	$10 Rx	$10-30 (30 day)
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus	Kaiser	Kaiser
Individual/Family Brand & Specialty Rx Deductibles	none	$200/$500	none	$200/$500	Included w/ Medical ded	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	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‡ $10 at Other Network	$0 at Costco‡ $9 at Other Network	$0 at Costco‡ $10 at Other Network	Deductible, then $0 at Costco or $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 30 day supply
Brand co-pay/30 days supply	$25	$35	$35	$35	Deductible, then $35	Deductible, then $35	$35	$10 up to 100 day supply	$30 up to 30 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)	Deductible, then $35 (Must Use Navitus Mail)	$35 Must Use Navitus Mail	$10 up to 30 day supply	$30 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	Deductible, then $0-$90	$0-$90‡	$10-$10/up to 100 day supply	$20-$60 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	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.