FULL TIME FACULTY EMPLOYEES (DUAL COVERAGE)

$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* Pre-Tax Premium:	Selection	*Amount per Month* Pre-Tax Premium:	Selection
PPO COST SHARING PLANS - Anthem Blue Cross	***With Dental Plan 1***		***With Dental Plan 2***	
40463A 100%-A, $20 Co-pay, $0 Deductible, Rx $5-$20	$199.77	☐	$166.87	☐
40463B 100%-B, $20 Co-pay, $100 Ind./$300 Fam. Deductible, Rx $200/$10-$35	$109.77	☐	$76.87	☐
40463C 80%-C, $20 Co-pay, $200 Ind./$500 Fam. Deductible, Rx $5-$20	$40.77	☐	$7.87	☐
40463D 80%-K, $30 Co-pay, $1,000 Ind./$2,000 Fam. Deductible, Rx $9-$35	$0.00	☐	$0.00	☐
PPO CO-PAY PLAN - Anthem Blue Cross				
M213 Platinum+ Primary Care Plan, $0 Co-pay (**ADD'L CO-PAYS FOR SOME SERVICES**), $0 Deductible, Rx $9-$35	$51.27	☐	$18.37	☐
HMO PLAN PROVIDER - Kaiser Permanente				
234480-0027 / ACN $10 Co-Pay, $0 Deductible, Rx $10	$0.00	☐	$0.00	☐
234480-0028 / ACN $20 Co-Pay, $0 Deductible, Rx $10-$20	$0.00	☐	$0.00	☐
DENTAL PLAN PROVIDER - Delta Dental				
7079 1300 (DENTAL PLAN 1) 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) PPO Plan- $1,500 max. per year			INCLUDED IN MEDICAL PREMIUM	
VISION PLAN PROVIDER - VSP				
2536 / 64253ACN Signature Plan C- $5 Co-pay, 2nd Pair	INCLUDED IN MEDICAL PREMIUM			
LIFE INSURANCE PLAN PROVIDER - Mutual of Omaha				
G000AMP6-A002 $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 Benefits to complete required documents.

I am eligible for the 75% couple's rate with Spouse/Domestic Partner Name: _____ **Spouse or DP SSN:** _____

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
Faculty Plans

2025-2026	Anthem	Anthem	Anthem	Anthem	Anthem	Anthem	Kaiser	Kaiser
	100-A $20	100-B $20	80-C $20	80-K $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	$200/$500	$1,000/$2,000	$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	$3,000/$6,000	$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	20% after Ded	20% after Ded	30% after Ded	$100/$250	$0	$0
Laboratory Procedures	0% after Ded	0% after Ded	20% after Ded	20% after Ded	30% after Ded	$0/$50	$0	$0
Diagnostic X-rays	0% after Ded	0% after Ded	20% 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	20% 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	20% after Ded	20% after Ded	30% after Ded	$200/day	$0	$0
Surgery, Outpatient (performed in Surgery Center)	0% after Ded	0% after Ded	20% 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	20% 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	20% after Ded	20% after Ded	30% after Ded	$200/day	$0	$0
OUTPATIENT: Facility Based Care (preauth required)	0% after Ded	0% after Ded	20% 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	20% 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	20% 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	20% 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	20% after Ded	20% after Ded	30% after Ded	$0	$10	$20
Durable Medical Equipment (DME)	0% after Ded	0% after Ded	20% 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	20% 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 5-20	Rx 200/10-35	Rx 5-20	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	$200/$500	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	$1,500/$2,500	$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‡ $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	$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	$20	$35	$20	$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	$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)	$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-$50‡	$0-$90‡	$0-$50‡	$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.