ANTELOPE VALLEY COLLEGE

# FULL TIME FACULTY EMPLOYEES
## $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**<br>100%-A, $20 Co-pay, $0 Deductible, Rx $5-$20 | $701.52 | ☐ | $668.62 | ☐ |
| **40463B**<br>100%-B, $20 Co-pay, $100 Ind./$300 Fam. Deductible, Rx $200/$10-$35 | $581.52 | ☐ | $548.62 | ☐ |
| **40463C**<br>80%-C, $20 Co-pay, $200 Ind./$500 Fam. Deductible, Rx $5-$20 | $489.52 | ☐ | $456.62 | ☐ |
| **40463D**<br>80%-K, $30 Co-pay, $1,000 Ind./$2,000 Fam. Deductible, Rx $9-$35 | $214.52 | ☐ | $181.62 | ☐ |
| **70112B (HSA 5000 - *SPOUSE INELIGIBLE* )**<br>Deductible then 70% & Rx $9-$35, $5,000 Ind./$10,000 Fam. Deductible | $0.00<br>**NO DENTAL or VISION** | | | ☐ |
| ***PPO CO-PAY PLAN - Anthem Blue Cross*** | | | | |
| **M213**<br>Platinum+ Primary Care Plan, $0 Co-pay (**ADD'L CO-PAYS FOR SOME SERVICES**), $0 Deductible, Rx $9-$35 | $503.52 | ☐ | $470.62 | ☐ |
| ***HMO PLAN PROVIDER - Kaiser Permanente*** | | | | |
| **234480-0027 / ACN**<br>$10 Co-Pay, $0 Deductible, Rx $10 | $270.52 | ☐ | $237.62 | ☐ |
| **234480-0028 / ACN**<br>$20 Co-Pay, $0 Deductible, Rx $10-$20 | $235.52 | ☐ | $202.62 | ☐ |
| ***DENTAL PLAN PROVIDER - Delta Dental*** | | | | |
| **7079 1300 (DENTAL PLAN 1)**<br>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)**<br>PPO Plan- $1,500 max. per year | | | INCLUDED IN MEDICAL PREMIUM | |
| ***VISION PLAN PROVIDER - VSP*** | | | | |
| **2536 / 64253ACN**<br>Signature Plan C- $5 Co-pay, 2nd Pair | INCLUDED IN MEDICAL PREMIUM | | | |
| ***LIFE INSURANCE PLAN PROVIDER - Mutual of Omaha*** | | | | |
| **G000AMP6-A002**<br>$50,000 Emp. Term Group Life & AD&D, Decreases at age 70 | INCLUDED IN MEDICAL PREMIUM | | | |
| ***WAIVER of Active Benefits Enrollment*** | | | | |
| **WABE64253C**<br>Access Only to EAP, Teladoc, MDLive, Vida Health & Biometric Screenings | $0.00<br>**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-taxed 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
## 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.