

ANTELOPE VALLEY COMMUNITY COLLEGE: AVCFT: REGULAR FACULTY EMPLOYEES



2019-2020

	40463A	40463B	40463C	40463D	70112B	225543-1018	225543-1019
	Anthem	Anthem	Anthem	Anthem	Anthem Anchor Bronze (HSA Compatible)	Kaiser	Kaiser
	100-A \$20	100-B \$20	80-C \$20	80-K \$30		Trad HMO \$10	Trad HMO \$20
<b>MEDICAL- CALENDAR YEAR Deductibles &amp; Maximums</b>	<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>	<b>Member Pays</b>
Individual/Family Deductibles	\$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*	\$1,500/\$3,000	\$1,500/\$3,000
<b>PROFESSIONAL SERVICES</b>							
Office Visit (OV) co-pay	\$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%	20%	20%	30%	\$0	\$0
Diagnostic X-ray & Laboratory Procedures	0%	0%	20%	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	OV copay or hospitalization co-pay apply	OV copay or hospitalization copay apply
Preventive Care (includes physical exams & screenings)	0%, Ded Waived	0%, Ded Waived	0%, Ded Waived	0%, Ded Waived	0%, Ded Waived	\$0	\$0
<b>HOSPITAL &amp; SKILLED NURSING FACILITY SERVICES</b>							
Emergency Room visit (waived if admitted)	0%, \$100 co-pay	0%, \$100 co-pay	20%, \$100 co-pay	20%, \$100 co-pay	30%, \$100 co-pay	\$100	\$100
Inpatient Hospital (preauthorization required) - limits may apply	0%	0%	20%	20%	30%	\$0	\$0
Outpatient Hospital	0%	0%	20%	20%	30%	\$10	\$20
Surgery, Outpatient (performed in Surgery Center)	0%	0%	20%	20%	30%	\$10	\$20
Surgery, Outpatient (performed in a Hospital) - limits may apply	0%	0%	20%	20%	30%	\$10	\$20
<b>MENTAL HEALTH &amp; SUBSTANCE ABUSE TREATMENT</b>							
INPATIENT: Facility Based Care (preauth required)	0%	0%	20%	20%	30%	\$0	\$0
OUTPATIENT: Facility Based Care (preauth required)	0%	0%	20%	20%	30%	\$10	\$20
<b>OTHER SERVICES</b>							
Acupuncture - Limits apply	0%	0%	20%	20%	30%	\$10/30 visits combined w/chiro	\$10/30 visits combined w/chiro
Ambulance (Ground or Air)	0%, \$100 co-pay	0%, \$100 co-pay	20%, \$100 co-pay	20%, \$100 co-pay	30%, \$100 co-pay	\$50	\$50
Chiropractic - Limits apply	0%	0%	20%	20%	30%	\$10/30 visits combined w/acu	\$10/30 visits combined w/acu
Durable Medical Equipment (DME)	0%	0%	20%	20%	30%	no charge	no charge
Physical and Occupational Therapy - Limits apply	0%	0%	20%	20%	30%	\$10	\$20
<b>PHARMACY BENEFITS</b>							
	5-20	5-20	5-20	9-35	Anchor Bronze Rx	Trad HMO \$10	Trad HMO \$20
<b>Pharmacy Benefit Manager</b>	<b>Navitus</b>	<b>Navitus</b>	<b>Navitus</b>	<b>Navitus</b>	<b>Navitus</b>	<b>Kaiser</b>	<b>Kaiser</b>
Individual/Family Brand & Specialty Rx Deductibles	none	none	none	none	*Included w/ Med ded	none	none
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	\$1,500/\$2,500	\$1,500/\$2,500	\$1,500/\$2,500	\$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 \$5 at Other Network	\$0 at Costco \$5 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	\$10 up to 100 day supply	\$10 up to 100 day supply
Brand co-pay/30 days supply	\$20	\$20	\$20	\$35	Deductible, then \$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	\$20 Must Use Navitus Mail	\$20 Must Use Navitus Mail	\$35 Must Use Navitus Mail	Deductible, then \$35 (Must Use Navitus Mail)	\$10 up to 30 day supply \$10-\$10/up to 100 day supply	\$20 up to 30 day supply \$10-\$20/up to 100 day supply
Mail Order (Generic-Brand co-pay/90 days supply)	\$0-\$50	\$0-\$50	\$0-\$50	\$0-\$90	Deductible, then \$0-\$90	Kaiser Mail Order Pharmacy	Kaiser Mail Order Pharmacy
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
Note: 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.							
<b>7079 1300 / 7079 1350 - Delta Dental PPO Incentive Plan</b>	Delta Dental Premier Network- Plan 1: Incentive plan provides \$2,000 annual max on basic dental services (PPO Network provides \$2,200 annual max). Ortho for Children only; lifetime max \$1,500. Plan 2: Provides \$1,500 annual max on basic dental services (PPO Network provides \$1,700 annual max).						
<b>2606681A - Vision Service Plan (VSP)</b>	Vision Service Plan (VSP) - Plan C - VSP Signature Network provides Exam, Lenses & Frames every calendar year for a \$5 co-pay.						
<b>G000AMP6-A002 - Life Insurance Coverage</b>	No change to the benefit. \$50,000 Term Group Life/AD&D policy. Life will continue to be administered by Mutual of Omaha and will not be covered through SISC.						