SISC
Self-Insured Schools of California
Schools Helping Schools

ANTELOPE VALLEY COMMUNITY COLLEGE
AVCFT: REGULAR FACULTY RETIREES

2019-2020	40463K Anthem 100-A $20	40463L Anthem 100-B $20	40463M Anthem 80-C $20	40463N Anthem 80-K $30	225543-3018 Kaiser Trad HMO $10	225543-3019 Kaiser Trad HMO $20
MEDICAL- CALENDAR YEAR Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$0/$0	$100/$300	$200/$500	$1,000/$2,000	$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	$1,500/$3,000	$1,500/$3,000
PROFESSIONAL SERVICES						
Office Visit (OV) co-pay	$20	$20	$20	$30	$10	$20
Urgent Care co-pay	$20	$20	$20	$30	$10	$20
Specialists/Consultants co-pay	$20	$20	$20	$30	$10	$20
Prenatal, postnatal office visit co-pay	$20	$20	$20	$30	$0	$0
Scans: CT, CAT, MRI, PET etc.	0%	0%	20%	20%	$0	$0
Diagnostic X-ray & Laboratory Procedures	0%	0%	20%	20%	$0	$0
Infertility (diagnosis/treatment of causes of infertility subject to plan benefits)	Not covered	Not covered	Not covered	Not covered	OV copay or hospitalization copay apply	OV copay or hospitalization co-pay apply
Preventive Care (includes physical exams & screenings)	0%, Ded Waived	0%, Ded Waived	0%, Ded Waived	0%, Ded Waived	$0	$0
HOSPITAL & SKILLED NURSING FACILITY SERVICES						
Emergency Room visit (waived if admitted)	0%, $100 co-pay	0%, $100 co-pay	20%, $100 co-pay	20%, $100 co-pay	$100	$100
Inpatient Hospital (preauthorization required) - limits may apply	0%	0%	20%	20%	$0	$0
Outpatient Hospital	0%	0%	20%	20%	$10	$20
Surgery, Outpatient (performed in Surgery Center)	0%	0%	20%	20%	$10	$20
Surgery, Outpatient (performed in a Hospital) - limits may apply	0%	0%	20%	20%	$10	$20
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT						
INPATIENT: Facility Based Care (preauth required)	0%	0%	20%	20%	$0	$0
OUTPATIENT: Facility Based Care (preauth required)	0%	0%	20%	20%	$10	$20
OTHER SERVICES						
Acupuncture - Limits apply	0%	0%	20%	20%	$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	$50	$50
Chiropractic - Limits apply	0%	0%	20%	20%	$10/30 visits combined w/acu	$10/30 visits combined w/acu
Durable Medical Equipment (DME)	0%	0%	20%	20%	no charge	no charge
Physical and Occupational Therapy - Limits apply	0%	0%	20%	20%	$10	$20
PHARMACY BENEFITS	**5-20**	**5-20**	**5-20**	**9-35**	**Trad HMO $10**	**Trad HMO $20**
Pharmacy Benefit Manager	**Navitus**	**Navitus**	**Navitus**	**Navitus**	**Kaiser**	**Kaiser**
Individual/Family Brand & Specialty Rx Deductibles	none	none	none	none	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
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	$10 up to 100 day supply	$10 up to 100 day supply
Brand co-pay/30 days supply	$20	$20	$20	$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	$10 up to 30 day supply	$20 up to 30 day supply
Mail Order (Generic-Brand co-pay/90 days supply)	$0-$50	$0-$50	$0-$50	$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	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.

7079 2300 / 7079 2350 - Delta Dental PPO Incentive Plan	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).
2606682A - Vision Service Plan (VSP)	Vision Service Plan (VSP) - Plan C - VSP Signature Network provides Exam, Lenses & Frames every calendar year for a $5 co-pay.
G000AMP6-R003 - Life Insurance Coverage	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.