Retired FAC
23/24

AVCFT: FACULTY RETIREES
$17,500 DISTRICT HEALTH BENEFITS CAP
2023 - 2024 HEALTH PLAN ELECTION FORM

To make your selection: Circle the rate of the premium for the selected plan, initial, sign, date and return to HR - Benefits.

Effective 10/01/2023

BENEFIT PLANS:	*Amount per Month for 12 Months* Retiree Premium Single:	Retiree Premium 2-Party:	Retiree Premium Family:	Initial:	*Amount per Month for 12 Months* Retiree Premium Single:	Retiree Premium 2-Party:	Retiree Premium Family:	Initial:
PPO PLAN PROVIDER - ANTHEM BLUE CROSS:	***With Dental Plan 1***				***With Dental Plan 2***			
40463K BC PPO 100%-A, $20 Co-pay, Rx $5-$20, $0 Ind./$0 Fam. Deductible	$0.00	$495.27	$1,045.67		$0.00	$469.47	$1,001.37	
40463L BC PPO 100%-B, $20 Co-pay, Rx $200/$10-$35, $100 Ind./$300 Fam. Deductible	$0.00	$374.27	$890.67		$0.00	$348.47	$846.37	
40463M BC PPO 80%-C, $20 Co-pay, Rx $5-$20, $200 Ind./$500 Fam. Deductible	$0.00	$306.27	$805.67		$0.00	$280.47	$761.37	
40463N BC PPO 80%-K, $30 Co-pay, Rx $9-$35, $1,000 Ind./$2,000 Fam. Deductible	$0.00	$55.27	$487.67		$0.00	$29.47	$443.37	
HMO PLAN PROVIDER - KAISER PERMANENTE:								
234480-0027 / RCN Kaiser HMO w/ Chiro, $10 Co-Pay, Rx $10, $0 Ind./$0 Fam. Deductible	$0.00	$106.27	$546.67		$0.00	$80.47	$502.37	
234480-0028 / RCN Kaiser HMO w/ Chiro, $20 Co-Pay, Rx $10-$20, Ind. $0/Fam. $0 Deductible	$0.00	$75.27	$507.67		$0.00	$49.47	$463.37	
DENTAL PLAN PROVIDER - DELTA DENTAL:								
7079 2300 (DENTAL PLAN 1) DD PPO Standard Incentive Plan- $2,000 max. per year, 3rd Cleaning, Ortho: Children Only	INCLUDED IN MEDICAL PREMIUM							
7079 2350 (DENTAL PLAN 2) DD PPO Plan- $1,500 max. per year					INCLUDED IN MEDICAL PREMIUM			
VISION PLAN PROVIDER - VISION SERVICE PLAN:								
2606682A VSP Signature Plan C- $5 Co-pay, 2nd Pair	INCLUDED IN MEDICAL PREMIUM							
LIFE INSURANCE PLAN PROVIDER - MUTUAL OF OMAHA LIFE INSURANCE:								
G000AMP6-R003 MO $50,000 Emp. Term Group Life & AD&D	INCLUDED IN MEDICAL PREMIUM							

BENEFIT PAYMENT AUTHORIZATION: I understand that the monthly retiree premium applicable to the plan I have selected is due the 1st of each month, and that if the premium payments are not made in a timely manner my insurance coverage may be terminated.

Retiree Printed Name: **Date of Birth:**

Retiree Signature (required): **Date:**

Retiree Address:

Phone Number: **Email:**

BENEFIT PAYMENTS: All benefit premiums are 12 months, from October - September. Please make checks/money orders payable to Antelope Valley College and submit payment to Human Resources by the first of each month.

PREMIUMS: All medical, dental, and vision plans are tiered (single, 2-party and family) rates.

PLAN CHANGES: ONLY during 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 RETIREES: Coverage begins the **first of the month following retirement date.**

RESIGNATION/TERMINATION/LACK OF PAYMENT/AGE OFF: Benefits stop on the **last day of the month the employee meets district qualifications.**

SISC
Self-Insured Schools of California
Schools Helping Schools

Antelope Valley Community College District
2023/2024 Retired Faculty Plan Matrix

	Anthem 40463K	Anthem 40463L	Anthem 40463M	Anthem 40463N	Kaiser 234480-0027RCN	Kaiser 234480-0028RCN
	100-A $20	**100-B $20**	**80-C $20**	**80-K $30**	**Trad HMO $10**	**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
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 ($0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)	$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	Co-pay applies	Co-pay applies
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 (pre-auth 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 (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, all plans use ASH Network	0%	0%	20%	20%	$10/30 visits*	$10/30 visits*
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, all plans use ASH Network	0%	0%	20%	20%	$10/30 visits*	$10/30 visits*
Durable Medical Equipment (DME)	0%	0%	20%	20%	no charge	no charge
Physical and Occupational Therapy - Limits apply	0%	0%	20%	20%	$10	$20
Hearing Aids	Amount in excess of $700 allowance/24 months	Amount in excess of $700 allowance/24 months	20% and Amount in excess of $700 allowance/24 months	20% and 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

**30 visits Chiro/Acu combined*

PHARMACY BENEFITS						
Plan	**5-20**	**200/10-35**	**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	$200/$500	none	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	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	$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	$35 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-$90	$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

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.