AVMC 2026 Benefits

Select a category below to jump ahead:

- About Our New Plan(s)
- Medical Plan Design & Options
- Prescriptions
- HNAS

About Our NEW Medical Plan(s):

1. WHAT'S CHANGING ON JANUARY 1, 2026?

For 2026, our medical third-party administrator (TPA) for the EPO and PPO plans will no longer be Health Now Administrative Services (HNAS) – we will be moving to Luminare Health (LH). The Antelope Valley EPO and PPO plans will continue to utilize the Anthem medical network and Luminare Health will process medical claims and manage our plans. Prior to January 1, 2026, you will search for providers through Anthem anthem.com/ca/find-care/. Beginning January 1, 2026, you will be able to search for Anthem providers through the Luminare Health portal (myluminarehealth.com) and go directly to Luminare Health for claims and eligibility information as well as ID cards. In addition, our plans will utilize the Express Scripts (ESI) pharmacy network, but instead of Keenan, RxBenefits will be furnishing the customer support.

2. WHY ARE WE CHANGING TPAS?

We are making this change to enhance service, improve efficiency, and provide a more modern member experience. Luminare Health offers more efficient referrals and claims processing, instant access to your digital ID card and Explanation of Benefits (EOB) from your computer or your phone, and stronger connectivity to Anthem providers. Luminare Health offers enhancements such as streamlined claims, enhanced portal capabilities and 24/7 customer service.

3. WILL I BE RECEIVING NEW ID CARDS?

Yes, if you enroll in the Antelope Valley Medical Center EPO or PPO medical plan, you and your covered dependents will be receiving new Anthem ID cards which cover both medical and pharmacy benefits. Your ID card contains important plan information, telephone numbers, and claim submission instructions. Your ID card should be presented to your health care providers and pharmacies at the time services are received. You can also access an electronic version of your ID card through your Luminare Health member portal myLuminareHealth.com. Register at myLuminareHealth.com and select "Create My Account" in the "I am a Participant" section; you may register starting on or after January 1, 2026. You can also find a doctor, connect with Luminare Health customer services, access your benefit ID card using Luminare Health's mobile app available from Apple's App Store or Google Play. Beginning January 1, 2026, you must present your new Luminare Health ID Card to all doctors and specialists, pharmacies (including mail order), and hospitals and urgent care centers.

4. I'M ENROLLED IN KAISER, DOES THIS CHANGE IMPACT ME?

No. Kaiser benefits aren't impacted by this change. This FAQ only pertains to the Anthem medical plans. Kaiser members can disregard this FAQ document.

5. CAN I KEEP MY CURRENT DOCTOR?

Yes, as long as your physician or provider is still within the Anthem Prudent Buyer Network. Use the find a provider tool on the Anthem member portal site anthem.com/ca to verify that your current doctor is in network. Anthem will remain as our medical network; please continue to seek care at AVMC or with Anthem providers.

6. WHAT IF MY DOCTOR'S OFFICE DOESN'T RECOGNIZE LUMINARE HEALTH'S NAME?

If your provider is unsure who Luminare Health is, ask them to call the customer service number on your new Anthem ID Card to verify eligibility and benefits. Luminare Health will confirm your coverage and assist your provider directly.

7. WHAT IF I'M UNDERGOING TREATMENT WITH MY CURRENT PLAN?

It is important to recognize that if you or your family members are in the middle of treatment at the time of your change in health plans, to ask how you will handle the transition. The typical member concern is whether their treating physician/specialist or hospital is in-network but since Luminare Health will also be working with the Anthem network, this won't be an issue for most of undergoing treatment. To find out if you qualify for transition of care, please contact Luminare Health Customer Service at 833-271-4121 for help with claims, benefits, or network question in advance of your next visit or scheduled surgery or in-patient admission.

8. WHAT HAPPENS TO CLAIMS CURRENTLY IN PROCESS?

Any claims in progress as of December 31, 2025, will continue to be handled by HNAS until completed. You will continue to receive the Explanation of Benefits from HNAS for claims incurred up to December 31, 2025, that HNAS will process. You may still contact HNAS for questions about your 2025 claims well into 2026.

9. WHAT IF I HAVE MEDICAL APPOINTMENTS SCHEDULED IN JANUARY 2026?

You can keep your scheduled appointments. Just bring your new Anthem ID card and provide it to your provider's office at check-in. If you have a scheduled surgery or in-patient stay scheduled for 2026, please contact Luminare to ensure precertification is completed.

10. HOW DO I SEARCH FOR DOCTORS IN-NETWORK?

Finding a provider is easy! Follow the instructions below:

Accessing care in California:

- Visit anthem.com/ca
- Select your plan network – Prudent Buyer Network
- Select the type of provider you need (e.g., doctor, facility, mental health).
- Enter your preferred location.
- Select whether you want to search by provider specialty or provider name.

Accessing care outside of California:

- Visit anthem.com/ca
- Find care
- Choose your search location by changing state.
- Select whether you want to search by provider name, specialty or places by name or type.

Relevant results will be displayed. Browse and refine your results by distance, languages spoken by provider, gender, etc.

11. ARE THE DEDUCTIBLES FOR THE ANTELOPE VALLEY MEDICAL CENTER GROUP HEALTH PLANS BASED ON A CALENDAR YEAR?

The deductibles for the Antelope Valley Medical Center's group health plans are based on a Calendar Year; they reset every January.

12. WILL THIS CHANGE AFFECT MY MEDICAL OR PHARMACY BENEFITS?

Yes. Some benefits will be changing in 2026. Please refer to the 2026 Medical Summary of Benefits and Coverage (SBC) plan documents for plan details. The digital SBCs can be found on avmc.mybenefits.life (AVMC's mobile friendly benefits website).

13. WHAT IF I RECEIVE A BILL FOR 2025 SERVICES?

If you receive a bill for 2025 services, please contact HNAS at 1-866-507-6558 for assistance or if your provider will process your claim, please direct your doctor's office to submit the claim to HNAS

14. WHO CAN I CALL FOR QUESTIONS REGARDING MY PLAN STARTING JANUARY 1, 2026?

Contact Luminare Health Customer Service at 833-271-4121 for help with claims, benefits, or network questions.

Medical Plan Design and Options:

15. WHAT IS THE DIFFERENCE BETWEEN THE PPO and EPO PLAN OPTIONS?

Consider the PPO (Preferred Provider Plan) if:

- You want to have access to out-of-network providers
- You want to access some benefits, such as PCP and specialist visits, without having to meet a deductible first

Consider the EPO (Exclusive Provider Plan) if:

- You want lower, predictable out-of-pocket costs
- You like having one doctor to manage your care
- You are happy with the selection of network providers
- You don't see any doctors that are out-of-network.
- You have convenient access to Anthem and AVMC facilities.

16. AM I REQUIRED TO DESIGNATE A PRIMARY CARE DOCTOR FOR MYSELF AND EACH FAMILY MEMBER?

No, you are not required to designate a Primary Care Physician (PCP). With Antelope Valley Medical Center's EPO and PPO plans, you are free to seek care from any in network provider you choose, though you will benefit significantly from reduced service fees when you seek care at Antelope Valley Medical Center.

17. DO I NEED A REFERRAL TO SEE A SPECIALIST?

No, you do not need a referral to see a specialist; however, we always recommend making sure your specialist is in-network with Anthem so you can benefit from negotiated reduced fees.

18. DO I NEED PRE-CERTIFICATION FOR ANY SERVICES?

Yes, before you receive certain medical services or procedures, your health plan requires a doctor to confirm that these requested services are considered medically necessary under your plan. Even if some services or therapies are performed in your doctor's office, you may still need a pre-certification – your doctor will connect with Anthem for the pre-certification. This is also true of prescription drug prescriptions which need pre-authorization, please contact RxBenefits for assistance.

19. WHAT IS THE DIFFERENCE BETWEEN PREVENTIVE SERVICES VERSUS DIAGNOSTIC SERVICES?

Preventive care is precautionary, and diagnostic care is used to find the cause of existing symptoms. For example, if your physician suggests you have a colonoscopy because of your age, that's preventive care. But, if your physician suggests a colonoscopy to see what's causing your symptoms, that's diagnostic care, and you may need to pay part of the cost (this is your "cost share"). Perhaps you go in to have your annual well-woman visit and based on the results, your physician orders additional tests. Your initial well-woman visit is considered preventive care; however, the additional tests are considered diagnostic care, and you will need to pay part of the cost.

20. IS PREVENTIVE CARE COVERED UNDER OUR PLANS?

Adhering to the Affordable Care Act (ACA), preventive services such as annual exams, screenings and recommended immunizations are covered at no cost In-Network.

21. WHAT ARE OUT-OF-POCKET COSTS?

Out-of-pocket costs are your expenses for medical care that aren't reimbursed by the insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services, plus all costs for services that aren't covered. Review each plan for their respective annual out-of-pocket calendar year maximums.

22. WHAT TELEMEDICINE SERVICES ARE OFFERED WITH OUR NEW PLANS?

Telemedicine provides you access to doctors 24 hours, 7 days a week who can consult over the phone or video conference, from your home, office or on the road. U.S. board-certified physicians can diagnose, recommend treatment, and submit prescriptions to your pharmacy of choice. Telemedicine, through Anthem's LiveHealth Online, is available to all employees who are enrolled in one of our Anthem medical plans. Telemedicine services are available for just a $10 copay. Telephone consultations with other physicians will be paid under the appropriate benefit category.

23. WHAT IS AN EMBEDDED DEDUCTIBLE VERSUS AN AGGREGATE DEDUCTIBLE?

The EPO and PPO plans have **Embedded Deductibles** – Each family member has an individual deductible in addition to the overall family deductible. This means that if an individual in the family reaches his or her individual deductible before the family deductible reached, his or her services will be processed by the insurance company at the after deductible levels, regardless of if the family deductible has been met.

Prescriptions:

24. ARE PRESCRIPTIONS SUBJECT TO A DEDUCTIBLE?

For the PPO and EPO plans, you just pay the member copays for your prescriptions before having to meet your deductible.

25. ARE PRESCRIPTIONS SUBJECT TO AN OUT-OF-POCKET MAX?

Yes, your out-of-pocket max for prescriptions are:

- **EPO**: $2,000/ Person, $5,000/ Family
- **PPO**: $2,000/ Person, $6,000/ Family

26. HOW DO I OBTAIN A PRESCRIPTION?

To obtain prescriptions, use your Express Scripts (ESI)-RxBenefits medical ID card. Prescription benefits for both Anthem plans are administered through Express Scripts (ESI)-RxBenefits. If you have any questions regarding prescriptions, please contact Express Scripts (ESI)-RxBenefits at 800-334-8134 effective 1/1/2026. You will also be able to register online at rxbenefits.com effective 1/1/2026.

27. HOW DO I KNOW IF MY PRESCRIPTIONS WILL BE COVERED UNDER THIS PLAN?

A drug formulary is a list of prescription drugs covered by your pharmacy plan. Formulary lists consist of generics and brand names that are reviewed regularly based on their effectiveness and cost. Most prescription drug formularies separate the medications they cover into Generics, Preferred Brand, Non-preferred Brand and Specialty drugs. These groupings generally range from least expensive to most expensive cost to you. “Preferred” drugs will cost you less than “non-preferred” drugs. Our plans have four prescription tiers. You can find a list of formulary drugs on the RxBenefits website or by calling 800-334-8134.

28. IS MAIL ORDER AVAILABLE FOR PRESCRIPTIONS UNDER THIS PLAN?

Yes, this plan allows you to obtain a 90-day supply of ongoing maintenance medications via mail order or retail pharmacies. You can submit your order online at member.rxbenefits.com or by calling the pharmacy telephone number on your ID card.

29. IS RETAIL 90 AVAILABLE FOR PRESCRIPTIONS UNDER THIS PLAN?

Yes, effective 1/1/26 members will be eligible to obtain a 90-day supply from retail in-network pharmacies for maintenance drugs. You can seek assistance on this new feature at member.rxbenefits.com or by calling the pharmacy telephone number on your ID card (800) 334-8134.

30. DO I NEED TO OBTAIN PRIOR AUTHORIZATION FOR ANY PRESCRIPTIONS?

Yes, in order to ensure safe and appropriate use of certain medications, your prescription benefit program may have prior authorization, step therapy, and/or quantity limits for certain medications. All active prior authorizations for medical and pharmacy services should automatically transfer to ESI – RxBenefits but should you encounter difficulties, please contact ESI-RxBenefits by calling 800-334-8134.

- Prior authorization requires you and your physician to obtain approval from Express Scripts (ESI) - RxBenefits prior to medication being dispensed.
- Step therapy is when your prescription benefit requires you to try another medication (usually a generic) prior to starting the medication your physician prescribed (usually a brand).
- Quantity limits only allow you to receive up to a maximum dosage or quantity for certain medications, based on clinically approved prescribing guidelines.

Register at member.rxbenefits.com to determine if your medication(s) is subject to prior authorization, step therapy, and/or quantity limit requirements.

HNAS

31. HOW DO I CONTACT HNAS FOR QUESTIONS?

The HNAS customer service phone number is 1-866-507-6558 and their email address is hnascustomerservice@hnas.com. HNAS customer service is available to assist with immediate medical insurance questions or concerns. Reach out when you have general benefit questions regarding your medical insurance, questions on how a medical claim is processed or need immediate claims assistance, you need help finding a contracted provider, you need assistance ordering Medical ID cards, or you have preauthorization questions.

32. WHAT IS AVAILABLE VIA THE HNAS MEMBER PORTAL AND MOBILE APP?

Health Now has a member portal (myHNAS.com) , so employees and their enrolled dependents can access plan information, including claims status, and a temporary ID card, at any time of the day. The member portal will allow you to:

- Review eligibility and plan information for you and your covered dependents
- View claims details for you and your covered dependents*
- Access Explanation of Benefits (EOB) documents related to medical claims
- Track steps and access wellness programs
- View, print, or download your current ID card and request new ID cards
- Access an electronic summary of benefits and coverages
- Locate participating doctors or hospitals
- View deductible/accumulator information related to current and past health plan enrollments
- Change your current coverage due to a life event, if applicable

To register, go to myHNAS.com, and select “Register Now.”

You can also download the myHNAS mobile (available via the App Store or Google Play) for access to your benefit portal on the go.

If you do not already have a HNAS member portal account, you **must** register before December 31, 2025, in order to gain access to the HNAS portal. If you have any questions on your medical claims incurred in 2025 or earlier, you will need to call HNAS Member Service on the back of the previous ID Card. The HNAS Member Service number is 1-866-507-6558.

Please refer to the Benefit Guide, Summary of Benefits and Coverage (SBC) and Certificates for more details.