SISC
Self-Insured Schools of California
Schools Helping Schools

Yosemite Community College District

2025-2026 Active Employee Plan Election Form

Plan Year Effective October 1, 2025 through September 30, 2026

EMPLOYEES may choose between one (1) Kaiser HMO and four (4) Blue Shield PPO medical options. YCCD currently offers two plans (Kaiser HMO and Blue Shield 80G) with no premium cost to the employee and includes coverage for elligible dependents. Three plans do have a monthly premium cost to you which will be deducted from your paycheck (requires completion of a POP form). Your choices are listed below. You should review the information packet provided for each plan for details, limitations and exclusions to help you choose the benefits that best meets the needs of you and/or your family. Please make your choice by checking the box and initialing under the plan you wish to enroll.

For Current Active Employees-During Open Enrollment -If you are NOT making any changes, you do not need to return this form

MEDICAL PLAN OPTIONS - SELECT ONE:

SELECT A PLAN FROM CHOICES BELOW AND INITIAL BY YOUR SELECTED PLAN:

	District Paid Plan **Kaiser HMO**	District Paid Plan **Blue Shield PPO 80%-G Plan**
Medical Plan:	606394-0058 ACN,ALN,AMN	SISC BSC - SC P021000/01/02
Calendar Year Individual /Family Deductible(s):	Not Applicable	$500 / $1,000
Calendar Year Co-Insurance Maximum:	Med/RX: $1,500/$3,000	Med $2,000/$4,000, Rx $2,500/$3,500
Office Visit Co-Pay & B.S.Behavioral Health Co-Pay	$30 Co-Pay	$30 Co-Pay
Treatment Co-Insurance after deductible is met:	Not Applicable	20% after deductible
Prescription - Retail	$10 Generic / $30 Brand	$10 Generic / $35 Brand
Prescription Drug/Calender Year/Brand Name Deductible- Not applicable to Generic Drugs	Not Applicable	$200 Single / $500 Family (January 1 thru December 31)
TOTAL PREMIUM PAID BY YCCD	$2,118.00	$2,164.00
Employee Monthly Premium:	**$0.00**	**$0.00**
	I Select Kaiser HMO Plan:	**I select BS 80G Plan:**

NOTE!!!
If changing from Kaiser to to Blue Shield, or from Blue Shield to Kaiser - you must also complete the appropriate enrollment form.

Buy Up Rates Updated 10/17/25

THESE PLANS REQUIRE A "POP" FORM	Buy-Up - 80/20% **Blue Shield PPO 80%-C**	Buy-Up - 90/10% **Blue Shield PPO 90%-G**	Buy-Up - 100% **Blue Shield PPO 100%-D**
Medical Plan:	SISC BSC - SC P031000/01/02	SISC BSC - SC P041000/01/02	SISC BSC - SC P011000/01/02
Calendar Year Individual /Family Deductible(s):	$200 / $500	$500 / $1,000	$300 / $600
Calendar Year Co-Insurance Maximum:	Med $1,000/$3,000, Rx $2,500/$3,500	Med $1,000/$3,000, Rx $2,500/$3,500	Med $1,000/$3,000, Rx $2,500/$3,500
Office Visit Co-Pay & B.S.Behavioral Health Co-Pay	$20 Co-Pay	$20 Co-Pay	$20 Co-Pay
Treatment Co-Insurance after deductible is met:	20% after deductible	10% after deductible	No Charge after deductible
Prescription - Retail	$10 Generic / $35 Brand	$9 Generic / $35 Brand	$10 Generic / $35 Brand
Prescription Drug/Calender Year/Brand Name Deductible- Not applicable to Generic Drugs	$200 Single / $500 Family (January 1 thru December 31)	Not Applicable	$200 Single / $500 Family (January 1 thru December 31)
TOTAL PREMIUM	$2,404.00	$2,433.00	$2,591.00
YCCD Contributes:	$2,164.00	$2,164.00	$2,164.00
Employee Cost per Month for Premium	**$204.00**	**$233.00**	**$391.00**
	I select BS 80c Plan:	**I select BS 90G Plan:**	**I select BS 100D Plan:**

DENTAL PLAN OPTIONS - SELECT ONE CHOICE

SELECT A DENTAL PLAN FROM THE TWO CHOICES BELOW AND INITIAL

DELTA PREMIER INCENTIVE PLAN-INCLUDES SOME ORTHODONTIC COVERAGE	**DELTA PPO (DPO) PLAN-EXCLUDES ORTHODONTIC COVERAGE**
Coverage begins at 70% and increases to 100%, increase in coverage occurs every calendar year plan is utilized by each covered member	Coverage begins at 100%, I understand that if I use a non-preferred provider that I will be responsible for greate portion of costs
I select Delta Premier Incentive Plan:	***I select Delta PPO/DPO Plan:***

I acknowledge that I cannot make changes to plans until a subsequent Open Enrollment period, generally held in August with an October 1st effective date. I also understand that if, during open enrollment, I change to the Premier Incentive Plan my dental benefits will begin at 70%.

VISION SERVICE PLAN - AUTOMATIC ENROLLMENT

AUTOMATIC ENROLLMENT

Documentation is required for enrollment of dependents

Spouse: Marriage Certificate + First Page of Most Recent Taxes + Copy of Spouses' Social Security Card
If adding a dependent child, for each child: Copy of Birth Certificate + Copy of Social Security Card

By signing below, I understand that the only time I may change from one plan to another plan is during the district's designated Open Enrollment Period for an effective date of October 1.

I also acknowledge that if I gain a new dependent (i.e. marriage, birth or adoption), I can add those dependents by completing a SISC Membership Change Form and by providing proper documentation to submit to the YCCD-Benefits Office within 30 days of the event date. Missing this window means that I must wait until the next Open Enrollment period.

Print Name:	Signature:

Last four of SSN:	[ ]Certificated/Faculty [ ]Classified [ ]Management	Date:

If you have enrollment changes, you will receive new ID cards in the mail. Please contact the customer service number on your ID card to order additional ID cards.