

## Yosemite Community College District

### 2024-2025 Active Employee Plan Election Form

Effective October 1, 2024 thru September 30, 2025, EMPLOYEES may choose between one (1) Kaiser HMO and four (4) Blue Shield PPO medical options. 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:

Medical Plan:  
Calendar Year Individual /Family Deductible(s):  
Calendar Year Co-Insurance Maximum:  
Office Visit Co-Pay & B.S.Behavioral Health Co-Pay  
Treatment Co-Insurance after deductible is met:  
Prescription - Retail  
Prescription Drug/Calendar Year/Brand Name  
Deductible- Not applicable to Generic Drugs  
TOTAL PREMIUM PAID BY YCCD  
**Employee Monthly Premium:**

District Paid Plan	
Kaiser HMO	
606394-0058 ACN,ALN,AMN	
Not Applicable	
Med/RX: \$1,500/\$3,000	
\$30 Co-Pay	
Not Applicable	
\$10 Generic / \$30 Brand	
Not Applicable	
\$1,962.00	
<b>\$0.00</b>	

**I Select Kaiser HMO Plan:**

District Paid Plan	
Blue Shield PPO 80%-G Plan	
SISC BSC - SC P021000/01/02	
\$500 / \$1,000	
Med \$2,000/\$4,000, Rx \$2,500/\$3,500	
\$30 Co-Pay	
20% after deductible	
\$10 Generic / \$35 Brand	
\$200 Single / \$500 Family (January 1 thru December 31)	
\$1,983.00	
<b>\$0.00</b>	

**I select BS 80G Plan:**

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

BUY UP RATES EXPECTED TO GO UP  
EFFECTIVE 10/2025

#### THESE PLANS REQUIRE A "POP" FORM

Medical Plan:  
Calendar Year Individual /Family Deductible(s):  
Calendar Year Co-Insurance Maximum:  
Office Visit Co-Pay & B.S.Behavioral Health Co-Pay  
Treatment Co-Insurance after deductible is met:  
Prescription - Retail  
Prescription Drug/Calendar Year/Brand Name  
Deductible- Not applicable to Generic Drugs  
TOTAL PREMIUM  
YCCD Contributes:  
**Employee Cost per Month for Premium**

Buy-Up - 80/20%	
Blue Shield PPO 80%-C	
SISC BSC - SC P031000/01/02	
\$200 / \$500	
Med \$1,000/\$3,000, Rx \$2,500/\$3,500	
\$20 Co-Pay	
20% after deductible	
\$10 Generic / \$35 Brand	
\$200 Single / \$500 Family (January 1 thru December 31)	
\$2,203.00	
\$1,983.00	
<b>\$220.00</b>	

**I select BS 80c Plan:**

Buy-Up - 90/10%	
Blue Shield PPO 90%-G	
SISC BSC - SC P041000/01/02	
\$500 / \$1,000	
Med \$1,000/\$3,000, Rx \$2,500/\$3,500	
\$20 Co-Pay	
10% after deductible	
\$9 Generic / \$35 Brand	
Not Applicable	
\$2,233.00	
\$1,983.00	
<b>\$250.00</b>	

**I select BS 90G Plan:**

Buy-Up - 100%	
Blue Shield PPO 100%-D	
SISC BSC - SC P011000/01/02	
\$300 / \$600	
Med \$1,000/\$3,000, Rx \$2,500/\$3,500	
\$30 Co-Pay	
No Charge after deductible	
\$10 Generic / \$35 Brand	
\$200 Single / \$500 Family (January 1 thru December 31)	
\$2,374.00	
\$1,983.00	
<b>\$391.00</b>	

**I select BS 100D Plan:**

#### DENTAL PLAN OPTIONS - SELECT ONE CHOICE

SELECT A DENTAL PLAN FROM THE TWO CHOICES BELOS AND INITIAL

##### DELTA PREMIER INCENTIVE PLAN-INCLUDES SOME ORTHODONTIC COVERAGE

Coverage begins at 70% and increases to 100%, increase in coverage occurs every calendar year plan is utilized by each covered member

**I select Delta Premier Incentive Plan:**

##### DELTA PPO (DPO) PLAN-EXCLUDES ORTHODONTIC COVERAGE

Coverage begins at 100%, I understand that if I use a non-preferred provider that I will be responsible for greater portion of costs

**I select Delta PPO/DPO Plan:**

I acknowledge that I cannot make changes to plan 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:

Social Security #:

☐ ]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.