SISC
Self-Insured Schools of California
Schools Helping Schools

Yosemite Community College District

RETIREE Plan Election Form - ALL OVER 65

Effective October 1, 2023 thru September 30, 2024, Retirees and Spouses over 65 with Medicare A/B may choose from one Kaiser Permanente Senior Advantage plan (KPSA) or three Blue Shield PPO options. *(Retirees/Spouses under 65 must complete a different election form.)* Your choices are listed below.

NOTE - If Retiree is over 65 w/Medicare A/B but spouse or dependent(s) are still UNDER 65, all parties must remain on an 'UNDER 65' plan (Co-Premium may apply.)

Review the information packet provided for each plan for details, limitations and exclusions to help you choose the benefits that best meet the needs of you and/or your family. Please make your choice by checking the box and initialing under the plan in which you wish to enroll.

If you are not making any changes, you do not need to return this form.

SELECT PLAN(S) FROM CHOICES BELOW

MEDICAL PLAN OPTIONS - ACTION REQUIRED

Medical Plan:	**Kaiser (KPSA) - Senior Advantage**	**Blue Shield 100-A; $20 CoPay: RX $200/$0-35**	**Blue Shield 100-A; $0 CoPay: Rx $0-35**	**Blue Shield CompanionCare**
Calendar Year Individual/Family Deductible(s):	Not Applicable	None	None	None
Calendar Year Co-Insurance Maximum:	Med/RX: $1,500/$3,000	Med $1,000/$3,000	Med $1,000/$3,000	See Plan Sheet
Office Visit Co-Pay & B.S.Behavioral Hlth Co-Pay	$30 Co-Pay	$0 Co-Pay	$0 Co-Pay	See Plan Sheet
Treatment Co-Insurance after deductible is met:	Not Applicable	Not Applicable	Not Applicable	See Plan Sheet
Prescription - Retail:	**Kaiser Pharmacy Only**	**Medicare Part D:**	**Medicare Part D:**	**Medicare Part D:**
Retail Network (30-90 day supply)	$10 Generic / $30 Brand	$0 Generic / $35 Brand	$0 Generic / $35 Brand	See Plan Sheet
Retail Out-of-Network (10 day supply)	n/a	$0 Generic / $35 Brand	$0 Generic / $35 Brand	See Plan Sheet
Network Mail Order (up to 90 days)	$10 Generic / $30 Brand	$0 Generic / $90 Brand	$0 Generic / $90 Brand	See Plan Sheet
Deductible (Brand Name Drugs ONLY)	Not Applicable	$200 Single / $500 Family	None	See Plan Sheet
Other information:	Includes Vision Coverage	$0 Generic available at all participating pharmacies	$0 Generic available at all participating pharmacies	$0 Generic available at all participating pharmacies
MONTHLY PREMIUM	☐ **Refer to Retiree Rate Sheet** CK & INITIAL	☐ **Refer to Retiree Rate Sheet** CK & INITIAL	☐ **Refer to Retiree Rate Sheet** CK & INITIAL	☐ **Refer to Retiree Rate Sheet** CK & INITIAL

IMPORTANT! If you are changing from Kaiser to Blue Shield OR from Blue Shield to Kaiser, you must also complete the corresponding enrollment form.

DENTAL & VISION OPTIONS

If you are not already signed up for Vision or Dental, you may NOT enroll now.

If you wish to **change** dental plans, please mark your selection here.

	VSP Vision Plan	**Delta Dental Premier/Incentive Plan**	**Delta Dental PPO Plan**
	www.vsp.com	www.deltadentalins.com	www.deltadentalins.com
CK	☐ Single - $10.50/month	☐ Single - $59.20/month	☐ Single - $53.00/month
CK	☐ 2-Party - $21.00/month	☐ 2-Party - $119.00/month	☐ 2-Party - $106.00/month
CK	☐ Family - $31.50/month	☐ Family - $167.40/month	☐ Family - $139.00/month

If you wish to **remove/add** a dependent, a SISC III CHANGE FORM is also required.

Retiree and Covered Participants

PRINT PLEASE
Retiree Name: ________ DOB: ________ SSN: ________
Medicare A/B Eff: ________ Age: ________

PRINT PLEASE
Spouse Name: ________ DOB: ________ SSN: ________
Medicare A/B Eff: ________ Age: ________

PRINT PLEASE
Dependent Name: ________ DOB: ________ SSN: ________
Medicare A/B Eff: ________ Age: ________

Documentation is required for enrollment of dependents: Marriage certificate for Spouse, Birth certificate for children.

I understand that the only time that 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. If I gain a new dependent (i.e. marriage, birth or adoption), I can add those dependents by completing a SISC Membership Change Form within 31 days of event date, provide proper documentation, and submit to the YCCD Benefits Office.

IMPORTANT! >> ☐ **THIS FORM IS ONLY FOR RETIREE (+ SPOUSE/DEP) OVER AGE 65 with Medicare A & B**

____
PRINT NAME

☐ **Classified**
☐ **Management**
☐ **Faculty**

________ ________
SIGNATURE **DATE**

You will not receive new cards unless you are changing health plans. Please contact the customer service number on your ID card to order additional ID cards. You do not receive cards for Dental or Vision.

This form will be placed in your personnel file.