SISC III SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

Yosemite Community College District **2018-2019**

RETIREE UNDER 65 - Plan Election Form

Effective October 1, 2018 thru September 30, 2019, Retirees below Medicare age may choose between one (1) Kaiser HMO and four (4) Blue Shield PPO medical options. A different election form is required if Retiree is (and spouse are) over age 65 w/Medicare A/B.

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.

SELECT PLAN(S) FROM CHOICES BELOW

MEDICAL PLAN OPTIONS - ACTION REQUIRED

Medical Plan:	Kaiser HMO	Blue Shield PPO 80%-G Plan
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 Hlth 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/Calendar Year/Brand Name Deductible- Not applicable on Generic Drugs	Not Applicable	$200 Single / $500 Family (January 1 thru December 31)
MONTHLY PREMIUM	**Refer to Retiree Rate Sheet**	**Refer to Retiree Rate Sheet**
	CK & INITIAL	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.

Medical Plan:	Blue Shield PPO 80-C	Blue Shield PPO 90%	Blue Shield PPO 100%-D
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 Hlth Co-Pay	$20 Co-Pay	$20 Co-Pay	$30 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/Calendar Year/Brand Name Deductible- Not applicable on Generic Drugs	$200 Single / $500 Family (January 1 thru December 31)	Not Applicable	$200 Single / $500 Family (January 1 thru December 31)
MONTHLY PREMIUM	**Refer to Retiree Rate Sheet**	**Refer to Retiree Rate Sheet**	**Refer to Retiree Rate Sheet**
	CK & INITIAL	CK & INITIAL	CK & INITIAL

DENTAL & VISION OPTIONS

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

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

If you wish to **remove/add** a member a SISC CHANGE FORM is required.

CK	VSP Vision Plan	CK	Delta Dental Premier/Incentive	CK	Delta Dental PPO Plan
	www.vsp.com		www.deltadentalins.com		www.deltadentalins.com
	Single - $12.40/month		Single - $ 64.00/month		Single - $ 60.00/month
	2 Party - $24.80/month		2 Party - $128.00/month		2 Party - $120.00/month
	Family - $37.20/month		Family - $168.00/month		Family - $158.00/month

Retiree and Covered Participants

PRINT PLEASE

Retiree Name: _____ DOB: _____ SSN: _____ Age: _____

PRINT PLEASE

Spouse Name: _____ DOB: _____ SSN: _____ Age: _____

PRINT PLEASE

Dependent Name: _____ DOB: _____ SSN: _____ 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! >> ☐ **DO NOT COMPLETE THIS FORM if Retiree (& spouse) are over 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 and does not need to be sent to SISC.