

BRIGGS ELEMENTARY SCHOOL DISTRICT

RETIREE HEALTH PLAN ELECTION FORM

Plan Year October 1, 2026 -September 30, 2027

I, _____, understand that as a retiree of the Briggs Elementary School District, I am eligible to continue district coverage on a retiree plan. I also understand that should I decline district coverage; I will not have the option to select district coverage in the future.

- ☐ I have chosen to enroll in the following product(s) for me and my eligible dependent(s) effective 10/01/2026:

(Please check one)

Blue Cross	Single	2 Party	Family
Retiree <65 (80-L \$30; Rx 200/10-35)	☐ \$1,175.00	☐ \$1,659.00	☐ \$2,105.00
Retiree <65 (80-G \$20; Rx 9-35)	☐ \$1,369.00	☐ \$1,932.00	☐ \$2,454.00
Retiree <65 (90-G \$20; Rx 9-35)	☐ \$1,498.00	☐ \$2,108.00	☐ \$2,677.00
Retiree <65 (HSA 5000; Rx HSA 5000)	☐ \$929.00	☐ \$1,324.00	☐ \$1,681.00
Retiree <65 (100-D \$20; Rx 9-35)	☐ \$1,614.00	☐ \$2,267.00	☐ \$2,879.00
Retiree 65+ W/A&B (100-A \$0; Rx 0-35 EGWP)	☐ \$687.00	☐ \$1,374.00	☐ \$1,805.00
Retiree 65+ W/A&B (100-A \$0; Rx 200/0-35 EGWP)	☐ \$668.00	☐ \$1,336.00	☐ \$1,763.00
CompanionCare	Single	2 Party	
Retiree 65+ W/A&B (Medicare Supp; Rx 9-35 EGWP) Direct Bill	☐ \$510.00	☐ \$1,020.00	
Kaiser Permanente	Single	2 Party	Family
Retiree <65 (\$10 OV, \$10 Rx)	☐ \$1,315.00	☐ \$1,868.00	☐ \$2,342.00
1w/Mcare Retiree 65+ W/A&B (\$10 OV, \$10 Rx/KPSA \$10)	☐ \$243.00	☐ \$1,558.00	☐ \$2,032.00
2 w/Mcare Retiree 65+ W/A&B (KPSA \$10)	☐ \$243.00	☐ \$486.00	☐ \$963.00

- ☐ **I decline all medical coverage offered.** By declining coverage, I understand that I give up my right to enroll in any district medical coverage at any subsequent date. I further understand that my decision is irrevocable.

Name

Signature

Date

BRIGGS ELEMENTARY SCHOOL DISTRICT

RETIREE DENTAL PLAN ELECTION FORM

Plan Year October 1, 2026 -September 30, 2027

I, _____, understand that as a retiree of the Briggs Elementary School District, I am eligible to continue district coverage on a retiree plan. I also understand that should I decline district coverage; I will not have the option to select district coverage in the future.

☐ I have chosen to enroll in the following product(s) for me and my eligible dependent(s) effective 10/01/2026:

(Please check one)

Delta Dental	Single	2 Party	Family
Retiree (DD 1000; 3rd Cleaning)	☐ \$50.30	☐ \$100.60	☐ \$132.90

☐ **I decline all dental coverage offered.** By declining coverage, I understand that I give up my right to enroll in any district dental coverage at any subsequent date. I further understand that my decision is irrevocable.

Name

Signature

Date

BRIGGS ELEMENTARY SCHOOL DISTRICT

RETIREE VISION PLAN ELECTION FORM

Plan Year October 1, 2026 -September 30, 2027

I, _____, understand that as a retiree of the Briggs Elementary School District, I am eligible to continue district coverage on a retiree plan. I also understand that should I decline district coverage; I will not have the option to select district coverage in the future.

☐ I have chosen to enroll in the following product(s) for me and my eligible dependent(s) effective 10/01/2026:

Please note, you may only select one vision plan.

Vision Service Plan	<i>Single</i>	<i>2 Party</i>	<i>Family</i>
Retiree (Signature C \$20/\$25)	☐ \$10.20	☐ \$20.40	☐ \$30.60

XP Health Vision	<i>Single</i>	<i>2 Party</i>	<i>Family</i>
Retiree (Signature C \$20/\$25)	☐ \$10.60	☐ \$21.20	☐ \$31.80

☐ **I decline all vision coverage offered.** By declining coverage, I understand that I give up my right to enroll in any district vision coverage at any subsequent date. I further understand that my decision is irrevocable.

Name

Signature

Date