## SOMIS UNION SCHOOL DISTRICT

## RETIREE HEALTH PLAN ELECTION FORM

**Plan Year October 1, 2026 -September 30, 2027**

I, _____, understand that as a retiree of the Somis Union 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

## SOMIS UNION SCHOOL DISTRICT

## RETIREE DENTAL PLAN ELECTION FORM

**Plan Year October 1, 2026 -September 30, 2027**

I,_____, understand that as a retiree of the Somis Union 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

## SOMIS UNION SCHOOL DISTRICT

## RETIREE VISION PLAN ELECTION FORM

**Plan Year October 1, 2026 -September 30, 2027**

I, _____, understand that as a retiree of the Somis Union 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** | ***Single*** | ***2 Party*** | ***Family*** |
|---|---|---|---|
| Retiree (Signature C $20/$25) | ☐$10.20 | ☐$20.40 | ☐$30.60 |

| **XP Health Vision** | ***Single*** | ***2 Party*** | ***Family*** |
|---|---|---|---|
| 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