

**PLAN ELECTION FORM
VISALIA UNIFIED SCHOOL DISTRICT
Classified Employee**

Classified employees that work six or more hours may choose between one of the following Blue Cross PPO medical plans. Please make your plan choice by checking the box under the plan and initial your selection.

For Health Plan Year 2026-27

	Basic Plan	Plan B
Blue Cross PPO Plan:	PBC 80-E/\$30	PBC 80-C/\$30
Individual/Family Deductible(s):	\$300/\$600	\$200/\$500
Co-Insurance Maximum (out of pocket):	\$1,000/\$3,000	\$500/\$1,500
Hosp, Surg, X-Ray and Lab:	80%	80%
Doctor Office Visits:	\$30 co pay	\$30 co pay
Other Professional:	80%	80%
Out-of-Network Payment:	Non-Par Fee	Non-Par Fee
AHC Prescription Drug Co-pay:	\$10-35/\$25-90	\$10-35/\$25-90
Brand Drug Deductible:	\$200/\$500	\$200/\$500
	Employee 10-Month Payroll Contributions (Sept - June)	
Monthly Cost to Employee:	\$0.00	\$57.60
Check one of the boxes to the right and initial your selection.	☐	☐
	Check Box	Initial
	☐	☐
	Check Box	Initial

Annual Notice of Spouse Overlay Requirements

- The **spouse/registered domestic partner** of a VUSD classified employee or retiree **who works 30 hours or more for an employer outside of VUSD and is eligible for medical benefits through their employer's group health plan must be enrolled in their employer's plan** in order to be covered as a dependent under the Visalia Unified School District health plan.
- If your spouse/registered domestic partner is not currently eligible for medical benefits where he or she works, but becomes eligible at a later date, he or she **must enroll in the employer Plan when first eligible and notify the district office.**
- It is the employee/retiree's responsibility **to report any change in the employment or marital status of the spouse/registered domestic partner**, or any other change to employee or dependents eligibility status must be reported immediately to the district on a district provided form.
- If a classified employee/retiree **is found to be in violation of the spousal overlay requirements, this will be considered fraud.** SISC will be notified to terminate the spouse/domestic partner's coverage retroactively. SISC will then seek to recover all paid claims.

My signature below, acknowledges that I have read and understand the spouse/registered domestic partner eligibility requirements for coverage under the VUSD health insurance. I certify that I am in full compliance with all requirements and failure to comply with all requirements would be considered fraudulent.

My signature authorizes the monthly payroll deductions for my chosen plan. I understand that I will remain in the chosen plan until I elect another plan during a subsequent District designated Open Enrollment Period for an effective date of October 1.

PRINT YOUR NAME CLEARLY

VUSD EMPLOYEE #

SIGNATURE

DATE