

**San Dieguito Union High School District
2022 Benefits Selection Form
Management / Supervisory / Confidential Employees**

Employee Name: _____ Site: _____

	<u>Medical</u>	<u>Dental</u>	<u>Vision</u>
Spouse	_____	_____	_____
Child	_____	_____	_____
Child	_____	_____	_____
Child	_____	_____	_____
Child	_____	_____	_____

In addition to the benefits indicated on the Benefit Selection Form, enrollment form(s) must be completed and attached. **All rates are monthly (processed on September – June payroll only).**

Medical Plan	
United Healthcare HMO Network 1	
_____ Employee Only	\$932.00
_____ Employee + 1	\$1,841.00
_____ Employee + Family	\$2,583.00
United Healthcare HMO Network 2	
_____ Employee Only	\$1,274.00
_____ Employee + 1	\$2,502.00
_____ Employee + Family	\$3,514.00
United Healthcare Alliance \$20/\$30	
_____ Employee Only	\$978.00
_____ Employee + 1	\$1,903.00
_____ Employee + Family	\$2,660.00
United Healthcare PPO	
_____ Employee Only	\$1,651.00
_____ Employee + 1	\$3,243.00
_____ Employee + Family	\$4,616.00
Cigna HMO	
_____ Employee Only	\$872.00
_____ Employee + 1	\$1,810.00
_____ Employee + Family	\$2,578.00
Kaiser	
_____ Employee Only	\$658.00
_____ Employee + 1	\$1,316.00
_____ Employee + Family	\$1,864.00

Dental Plan		
Delta Dental PPO		
_____ Employee Only		District Paid
_____ Employee + 1		\$60.80
_____ Employee + Family		\$93.10
Delta Dental DMO		
_____ Employee Only		District Paid
_____ Employee + 1		District Paid
_____ Employee + Family		District Paid

Vision Plan		
MES		
_____ Employee Only		\$14.20
_____ Employee + 1		\$25.57
_____ Employee + Family		\$36.66

*Employees receive \$396.24 medical credit

** Medical credit subject to potential increase effective 01/01/22

_____ **I elect no medical coverage – proof of coverage submitted**
 _____ **I elect no dental coverage – proof of coverage submitted**

I authorize San Dieguito Union High School District to deduct from a salary warrant the balance due, if any. I understand that any cash received in the form of increased disposable income will be subject to any appropriate taxes. I understand that the purpose of this program is to allow employees to select their qualified benefits within the guideline of the Internal Revenue Code, and that I may select either cash or qualified benefits, or a combination of both after providing for my required Medical and Dental employee coverages. These required coverages cannot be revoked or changed during the plan year. I understand that the selection of an insurance benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this program, that the premium for the contract selected may be adjusted by the insurance company issuing the contract, and, in most instances, an application for insurance must also be completed. I understand that I waive the right to cancel coverage after the monthly premium has been deducted. All changes must be made through the District and **not** directly with the insurance carrier.

Employee Signature

Date