San Dieguito Union High School District
2026 Benefits Selection Form
Management, Supervisory, Confidential Employees

Employee Name: _____ Site: _____

	Medical	Dental	Vision
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	$1,219.00
____	Employee + 1	$2,408.00
____	Employee + Family	$3,379.00
United Healthcare Harmony HMO		
____	Employee Only	$1,102.00
____	Employee + 1	$2,159.00
____	Employee + Family	$3,028.00
United Healthcare Alliance $20/$30		
____	Employee Only	$1,258.00
____	Employee + 1	$2,320.00
____	Employee + Family	$3,248.00
UMR Select Plus PPO		
____	Employee Only	$2,141.00
____	Employee + 1	$4,202.00
____	Employee + Family	$5,981.00
Cigna HMO		
____	Employee Only	$1,224.00
____	Employee + 1	$2,544.00
____	Employee + Family	$3,624.00
Kaiser		
____	Employee Only	$943.00
____	Employee + 1	$1,880.00
____	Employee + Family	$2,659.00

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

EyeMed		
____	Employee Only	$14.21
____	Employee + 1	$25.58
____	Employee + Family	$36.66

full-time employees receive a district health credit

(employees less than full-time receive pro-rated credit)

District Health Credit Information
$860.00

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