Carrollton CUSD #1
Benefits Election Form – Enrollment – CERTIFIED EMPLOYEES

Employee Name (please print)_____

Medical Insurance – United Healthcare (UHC)

I elect the following insurance coverage: MONTHLY COST

Plan 1 – *H.S.A Plan $1,500 deductible* ☐ Employee only - $27.62 ☐ Employee & Spouse - $775.56 ☐ Employee & Child(ren) - $629.34 ☐ Family - $1,377.28	**Plan 2 – *Traditional PPO $3,000 deductible*** ☐ Employee only - $58.09 ☐ Employee & Spouse - $847.43 ☐ Employee & Child(ren) - $693.11 ☐ Family - $1,482.45
Plan 3 – *Traditional PPO $1,500 deductible* ☐ Employee only - $91.08 ☐ Employee & Spouse - $925.25 ☐ Employee & Child(ren) - $762.17 ☐ Family - $1,596.34	☐ **Waive – NO MEDICAL COVERAGE** I acknowledge I was offered an employer sponsored group health plan that meets the Affordable Care Act's affordability and minimum value requirements, but I choose not to participate in the medical plan. By waiving I acknowledge that I may not be eligible for a subsidy on any private exchange plan.

Dental & Vision Insurance – Guardian

I elect the following insurance coverage: MONTHLY COST

DENTAL PLAN - BASE ☐ Employee only - $22.81 ☐ Employee + 1 - $41.88 ☐ Family - $79.38 ☐ WAIVE – I decline Dental (BASE) Coverage	**DENTAL PLAN – BUY-UP** ☐ Employee only - $51.26 ☐ Employee + 1 - $94.12 ☐ Family - $136.73 ☐ WAIVE – I decline Dental (BUY-UP) Coverage

VISION PLAN (VSP) ☐ Employee only - $9.51 ☐ Employee + 1 - $13.61 ☐ Family - $24.65	**VISION PLAN (DAVIS)** ☐ Employee only - $9.51 ☐ Employee + 1 - $13.61 ☐ Family - $24.65
☐ WAIVE – I decline Vision Coverage	

Life Insurance – Guardian

BASIC LIFE & AD&D ☒ $20,000 Policy Provided by the District at no cost **NOTE:** **For employees that work 30 or more hours per week.**	**This life insurance is optional and will be a deduction pending on which option(s) are selected. See Rate Sheet** **VOLUNTARY LIFE INSURANCE – *Rates based on Employee Age See Guardian Chart*** **WAIVE – NO COVERAGE** ☐ I decline all voluntary life coverage. I understand that I may be required to complete a health statement to enroll at a later time.

Acknowledgement & Signature: I understand the coverage I have elected is effective 1st of the month following date of hire

Date _____ ***Signature*** _____

CARROLLTON CUSD #1 - 2022/2023 SCHOOL YEAR

MEDICAL PLANS COMPARISON - UNITED HEALTHCARE

	PLAN 1 AEZ1 - H.S.A / 2V H.S.A	PLAN 2 BT4Y (Balanced) / 2V PPO	PLAN 3 BT4V (Balanced) / 2V PPO
DEDUCTIBLE (SINGLE / FAMILY)	$1,500 / $4,500	$3,000 / $6,000	$1,500 / $3,000
COINSURANCE	80%	80%	80%
MEDICAL OUT OF POCKET LIMIT (S/F)	$5,000 / $6,850	$6,250 / $12,500	$6,250 / $12,500
OUT OF POCKET LIMIT	*OOP - INCLUDES ALL DED, COINS, COPAYS*		
PREVENTATIVE SERVICES (NO DEDUCTIBLE)	100%	100%	100%
COPAYS			
PRIMARY DOCTOR	Ded/Coins	$35 , <19 $0	$35 , <19 $0
SPECIALIST	Ded/Coins	$70	$70
VIRTUAL VISIT (PPO Plans Only)	Ded/Coins	$0	$0
Major Diagnostics (PET scan, MRI,)	Ded/Coins	$400 copay	$400 Copay
EMERGENCY ROOM	Ded/Coins	Ded/Coins	Ded/Coins
URGENT CARE	Ded/Coins	$50	$50
PRESCRIPTION COPAYS	*(After Deductible is met)*		
TIER 1	$10	$10	$10
TIER 2	$35	$35	$35
TIER 3	$60	$60	$60

DENTAL PLANS COMPARISON - GUARDIAN

	BASE PLAN		**BUY-UP PLAN**	
DEDUCTIBLE (SINGLE / FAMILY)	$50/$150		$50/$150	
Waived for	Preventative		Preventative	
Charges covered for you (co-insurance)	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventative Care	80%	80%	100%	100%
Basic Care	70%	70%	80%	80%
Major Care	0%	0%	50%	50%
	-	-	50%	50%
Annual Maximum Benefit	$750		$1,500	
Lifetime Orthodontia Maximum	-		$1,000	

VISION PLANS COMPARISON - GUARDIAN

	VSP	**DAVIS**
Exam Copay	$10	$10
Materials Copay	$20	$20
Service Frequencies		
Exams	Every Calendar Year	Every Calendar Year
Lenses (glasses or contacts)	Every Calendar Year	Every Calendar Year
Frames	Every two Calendar Years	Every two Calendar Years