School Administrative Unit #93
Active Employee/New Hires Benefit Packet

This packet contains links to the documents and forms you need to learn about and enroll in the HealthTrust coverage offered by your employer. To access these materials, click on the orange “Download” buttons below.

BENEFITS



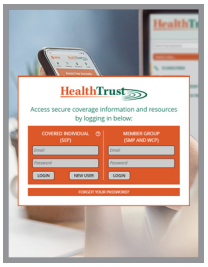
Benefit Education
Learn more about the benefit plans, programs and services available through your HealthTrust coverage.

DOWNLOAD



Benefit Comparison
Click on this link to learn more about your benefit plan options.

DOWNLOAD



Secure Enrollee Portal (SEP)
Create your account to access benefit resources, digital ID cards, coverage documents, a Secure Message Center, and single sign-on to Anthem, CVS Caremark®, Delta Dental, and more.

DOWNLOAD



Medical Benefits Overview
Make an informed decision for your health coverage! Read this concise guide designed to help you select a medical benefit option.

DOWNLOAD



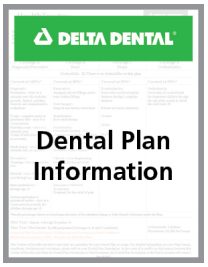
CVS Caremark Maintenance Choice®
Choose any CVS Pharmacy® or the CVS Caremark Mail Service Pharmacy® to obtain long-term prescriptions (up to a 90-day supply).

DOWNLOAD



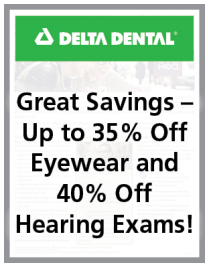
Anthem Vision Discount Flyer
Save up to 30 percent off the retail price of vision care products and services.

DOWNLOAD



Dental Outline of Benefits: OPTION 1C
This Outline of Benefits describes the specific coverage categories and level of benefits provided under your HealthTrust Dental Plan.

DOWNLOAD



Delta Dental Vision and Hearing Discount Flyer
Learn more about how to save money for vision and hearing products and services.

DOWNLOAD

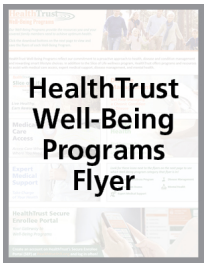


Delta Dental Health through Oral Wellness (HOW) Flyer

Learn how to take a free oral health assessment to see if you qualify for additional preventive dental benefits through this program.

DOWNLOAD

WELL-BEING RESOURCES



Well-Being Programs Flyer

HealthTrust Well-Being Programs provide the resources you and your covered family members need to achieve optimum health. Click on the link to learn about these programs and resources.

DOWNLOAD

SUMMARIES OF BENEFITS AND COVERAGES (SBC)



AB20IPDED(07L)-RX10/20/45/3K(L)

Click on the link to learn more about the specific cost share details for this medical plan offered by your employer.

DOWNLOAD



AB5(07L)-RX10/20/45/3K(L)

Click on the link to learn more about the specific cost share details for this medical plan offered by your employer.

DOWNLOAD



OA10(07L)-RX10/20/45/3K(L)

Click on the link to learn more about the specific cost share details for this medical plan offered by your employer.

DOWNLOAD

BENEFIT ADVANTAGE



FSA Overview

This brochure summarizes how FSAs work and can help you manage your medical and/or dependent care costs.

DOWNLOAD

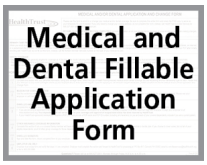


Health FSA Eligible Expenses List

Click on the link for a list of expenses eligible for reimbursement under the Benefit Advantage Flexible Benefits Plan offered by your employer.

DOWNLOAD

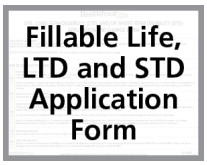
ENROLLMENT FORMS



Medical and Dental Application and Change Form

Use this fillable form to enroll in or change your medical and/or dental coverage.

DOWNLOAD



Life, LTD and STD Application and Change Form

Use this form to enroll in or change your disability and/or life insurance coverage and beneficiary information.

DOWNLOAD



Flexible Benefits Plan Enrollment Form

Use this form to enroll in a HealthTrust Benefit Advantage Flexible Benefits Plan.

DOWNLOAD

VIDEOS



Learn How to Create Your Secure Online Account

Click the video link to learn how to create your account on the Secure Enrollee Portal and access valuable resources.

WATCH VIDEO

HealthTrust

MEDICAL AND/OR DENTAL APPLICATION AND CHANGE FORM

Please use this form to enroll in or change your medical and/or dental coverage. Be sure to complete this entire form. If you only need to change your mailing address, do not complete this form; instead, log in to your account on HealthTrust's Secure Enrollee Portal (SEP), click on "Enrollment/ Membership Info" and scroll to the bottom of the page and click on "Update your Membership Information."

BE SURE TO FILL OUT EACH SECTION COMPLETELY. Include information on all your eligible family members at initial enrollment and when making changes. Failure to complete each section in full could delay the start of coverage.

PRIMARY CARE PROVIDER (PCP) SELECTION

When you enroll in a Access Blue New England℠ medical plan, each member of your family must choose their own PCP to coordinate medical care. Your PCP can be a family or general practitioner, an internist, or a pediatrician (for children). To access the Provider Directory, visit *www.healthtrustnh.org* and click on Coverages and Services, then Medical, and scroll down to Medical Plan Provider Directories. Should you decide to change your PCP after initially enrolling with HealthTrust, do not fill out this form. Instead, call the Anthem Member Services number on the back of your medical ID card.

DENTAL COVERAGE

- Dependent children are generally eligible for coverage as of the first of the month following their second birthday. In order for your children to be covered, you must enroll them at that time; coverage is not automatic.
- You are required to enroll for a 12-month period. Voluntary cancellations or membership downgrades are not allowed during this period unless you terminate employment, your dependent is no longer eligible, or you experience a qualified family status change.

HOW TO COMPLETE THIS FORM

STEP 1	**ENROLLEE (EMPLOYEE) INFORMATION** Complete this section with your personal information, using your full legal name. Select the type of HealthTrust-sponsored medical and/ or dental coverage you are requesting and the membership type for each. Please limit your selection to only those coverages offered by your employer and for which you are eligible. If you are applying for Retiree coverage, please complete the *Retiree Medical and/or Dental Application and Change Form.*
STEP 2	**REASON FOR COMPLETING FORM** Use this section to indicate the reason(s) for completing form. If you are a current HealthTrust Enrollee making a change to your existing membership, you must include the actual date of event. Please see your employer or call HealthTrust to obtain additional forms that are required for divorce/legal separation or retirement.
STEP 3	**ENROLLEE AND DEPENDENT INFORMATION** Complete this section as your membership should appear at HealthTrust. If you need additional space, use the *Additional Dependent(s) Information* section on the last page of this form. • If you are enrolling a dependent child age 26 or older who is disabled, complete a *Certification for a Mentally or Physically Disabled Child Over Maximum Age* form available through your employer or at *www.healthtrustnh.org*. **Your dependent child will not be added to your coverage until approval of incapacitated status has been received by HealthTrust.** • If your HealthTrust-sponsored medical plan requires a PCP, you must provide a PCP name and PCP ID number (including all characters) for you and each of your covered dependents.
STEP 4	**OTHER INSURANCE COVERAGE INFORMATION** Complete this section if you or a covered family member will have other coverage along with this plan or are transferring from another group medical or dental plan. If you choose to cover some, but not all of your eligible dependents, proof of other group coverage for those dependents you are not covering may be required.
STEP 5	**ENROLLEE SIGNATURE** Sign and date this form; return completed form to your employer.
STEP 6	**EMPLOYER USE ONLY** Employer must review form and verify that steps 1-5 are completed. Employer must complete this section and send via a secure message to HealthTrust Enrollee Services by logging in to their account on HealthTrust's Secure Member Portal and clicking on Message Center; forward to HealthTrust for processing at: PO Box 617, Concord, NH 03302; email to: *enrolleeservices@healthtrustnh.org*; or fax to: 603.226.2988

Questions? Please call us at 800.527.5001, Monday through Friday, 8:30 a.m. to 4:30 p.m.

MEDICAL AND/OR DENTAL APPLICATION AND CHANGE FORM

STEP 1: ENROLLEE (EMPLOYEE) INFORMATION

First Name	MI	Last Name	
Mailing Address	City	State	ZIP
Telephone / Employer Name	Marital Status ☐ Single ☐ Married ☐ Divorced/Legally Separated ☐ Widowed ☐ Other _____		

TYPE OF COVERAGE AND MEMBERSHIP REQUESTED

Medical Plan Type	Medical Membership	Dental Option #	Dental Membership
☐ Access Blue New England HMO* ☐ Access Blue HDHP* ☐ ☐ Lumenos Preferred Blue HDHP AB5 AB20IPDED ☐ Site of Service Access Blue New England HMO* ☐ Open Access PPO	☐ Single ☐ Two-Person ☐ Family ☐ Opt Out		☐ Single ☐ Two-Person ☐ Family ☐ Opt Out

***A PCP must be selected for HMO.**

STEP 2: REASON FOR COMPLETING FORM

☐ New Enrollee ☐ Open Enrollment ☐ Marriage ☐ Death ☐ Benefit Change ☐ Name Change	☐ Birth/Adoption ☐ Dependent No Longer Eligible (Dependent Name & **complete step 4**): _____ ☐ Divorce/Legal Separation ☐ Loss of Other Coverage (explain & **complete step 4**): _____ ☐ Part-Time to Full-Time ☐ Election of COBRA Coverage	☐ Other (explain): **Actual Date of Event**

STEP 3: ENROLLEE AND DEPENDENT INFORMATION (Complete this section as your membership should appear.)

NAME (First, MI, Last)	SOCIAL SECURITY NUMBER	Date of Birth Month/Day/Year	Relation to Enrollee	Gender	Enroll(ed) in		Primary Care Provider (for HMO Medical Type)	
					Medical	Dental	PCP ID# *(Find on www.healthtrustnh.org)*	First/Last Name/City/State
Employee Name			Self	☐M ☐F	☐	☐		
Spouse Name			Spouse	☐M ☐F	☐	☐		
Dependent Child Name**				☐M ☐F	☐	☐		
Dependent Child Name**				☐M ☐F	☐	☐		
Dependent Child Name**				☐M ☐F	☐	☐		

****If you are enrolling a dependent child age 26 or older who is disabled, complete a *Certification for a Mentally or Physically Disabled Child Over Maximum Age* form available through your employer or at *www.healthtrustnh.org.***

STEP 4: OTHER INSURANCE

OTHER MEDICAL INSURANCE COVERAGE INFORMATION (Complete if enrollment is due to loss/gain of other coverage.)

Do you or your family have medical coverage through another group or employer? ☐ Yes ☐ No

Are you or another dependent transferring coverage from another medical carrier? ☐ Yes ☐ No

Name of Insurance Company

Effective Date | Termination Date

Are you or any of your dependents eligible for Medicare? ☐ Yes ☐ No

Member Name _____

Part A (Hospital) Effective Date

Part B (Medical) Effective Date

OTHER DENTAL INSURANCE COVERAGE INFORMATION (Complete if enrollment is due to loss/gain of other coverage.)

Do you or your family have dental coverage through another group or employer? ☐ Yes ☐ No

Are you or another dependent transferring coverage from another dental carrier? ☐ Yes ☐ No

Name of Insurance Company

Effective Date | Termination Date

Medicare Claim Number _____

Is coverage due to end-stage renal disease? ☐ Yes ☐ No

STEP 5: ENROLLEE SIGNATURE

I hereby authorize HealthTrust and my employer to institute the enrollment(s) indicated on this form. If my employer requires a contribution for this coverage, this authorizes the appropriate payroll deductions. I understand that the effective date and termination date of my membership will be determined by HealthTrust and my employer in accordance with the plan rules. I understand that I must sign this form for claims to be processed. By signing this application, I attest to the accuracy and truthfulness and will provide documentation to HealthTrust upon request. I understand that any misrepresentation affecting the above named Enrollee's and/or Dependents' eligibility may result in retroactive cancellation of the medical and/or dental coverage and any charges incurred will be my liability. I understand it is my responsibility to notify my employer immediately when any Dependent no longer meets eligibility requirements of the plan.

Enrollee Signature _____ Date _____

STEP 6: EMPLOYER USE ONLY

Date of Hire | Date of Rehire | ☐ Full-Time | ☐ Part-Time Number of Hours Weekly _____ | ☐ COBRA

Billing Group Name | Employee Job Title

Medical Group/Carrier Number ☐ HRA | Effective Date of Coverage

Dental Group/Carrier Number | Effective Date of Coverage

Benefits Administrator Signature/Stamp

Date _____

Please complete section A, as necessary, and return with your application.

Enrollee Name _____ **Employer Name**_____

A. ADDITIONAL DEPENDENT(S) INFORMATION – If you are enrolling more than three dependent children, please complete the information below.

NAME (First, MI, Last)	SOCIAL SECURITY NUMBER	Date of Birth Month/Day/Year	Relation to Enrollee	Gender	Enroll(ed) in		Primary Care Provider (for HMO Medical Plan Type)	
					Medical	Dental	PCP ID# *(Find on www.healthtrustnh.org)*	First/Last Name/City/State
Dependent Child Name**				☐M ☐F	☐	☐		
Dependent Child Name**				☐M ☐F	☐	☐		
Dependent Child Name**				☐M ☐F	☐	☐		
Dependent Child Name**				☐M ☐F	☐	☐		
Dependent Child Name**				☐M ☐F	☐	☐		
Dependent Child Name**				☐M ☐F	☐	☐		

****If you are enrolling a dependent child age 26 or older who is disabled, complete a *Certification for a Mentally or Physically Disabled Child Over Maximum Age* form available through your employer or at www.healthtrustnh.org.**

Enrollee Signature_____ Date _____

It's Time to Enroll in Your VSP Vision Benefit!



Prioritize your health and budget with VSP and Monadnock Regional School District.

Affordable for the whole family.

With VSP® Vision Care, you get phenomenal care and great savings on exams, lens enhancements and frames or contacts so you can see and look your best without breaking the bank!

- Get an extra $20 to spend on Featured Frame Brands.[1]
- Enjoy even more savings when you shop online at Eyeconic®.
- VSP members also get access to exclusive savings on popular frame brands and contact lenses, additional discounts on things like LASIK, and more.

Make eye health a priority.

Your eye doctor is a key part of your healthcare team and can detect signs of more than 270 serious, chronic health conditions during an eye exam.[2]

VSP Premier Edge™ Promise

You now have access to the Premier Edge Promise, a worry-free eyewear guarantee. This protects you from the unexpected when you go to a Premier Edge location whether it's accidentally broken or damaged glasses, your prescription changes or if you don't love the glasses you chose.

The choice is yours!

VSP gives you thousands of in-network choices, including private practice doctors, regional and national optical retail chains, or online at **eyeconic.com®**. You'll get the most out of your benefits at a Premier Edge location.

vsp vision care

See why

9 out of 10

VSP members are happy saving more with VSP coverage.[3]

Get great eye care with a hefty side of savings when you choose VSP during your open enrollment between **04/16/2025-04/23/2025**

Scan QR code or visit **vsp.com/savings** to learn more.

vsp.com | 800.877.7195

1. Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
2. Full Picture of Eye Health, American Optometric Association, 2020
3. Patient Satisfaction Study, VSP Vision, 2024

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

Eyeconic is a VSP-affiliated company.

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VSP, Eyeconic, and eyeconic.com are registered trademarks, and VSP Premier Edge is a trademark of Vision Service Plan.
All other brands or marks are the property of their respective owners. 126038 VCCM

Classification: Public

Frequently Asked Questions

At VSP Vision Care, we're dedicated to offering a benefit that's simple to use and worry-free. Here are answers to questions we're asked most about our services for members.



VSP Member Services

vsp vision care

QUESTIONS	ANSWERS
What's the best way to communicate and promote the VSP® benefit to members?	We have a variety of member communication tools designed to increase awareness and understanding of the VSP benefit. They're easy to read and provide all the benefit information members need. Please review the enclosed Member Communications Overview, and then contact the Client Support Team at **800.216.6248** for more information or to order the tools you need.
Do members need an ID card?	An ID card or Member Vision Card isn't required for members to receive services or care. Members simply call a VSP network provider to schedule an appointment and tell them that they're a VSP member. The network provider and VSP handle the rest. If a member wishes to have an ID card, they can create an account and log in at **vsp.com** to print one.
How do members obtain a list of VSP network providers?	They should visit **vsp.com** or contact VSP at **800.877.7195**. Clients registered for the **Manage Your Plan** section at **vsp.com** can download customized VSP network provider lists as PDF or Excel files. Members and dependents have instant access through **vsp.com** to check coverage and eligibility, find a VSP network provider, and learn more about eye care wellness.
If members have questions about plan coverage, eligibility, or eye care wellness information, where should I direct them?	Members can also call VSP Member Services any time at **800.877.7195** or access our automated benefits information system to check eligibility or find a network provider. VSP Member Services is available Monday to Saturday, from 6:00 a.m. to 5:00 p.m., (Pacific Time); Closed on Sunday. ***Please note these new hours are effective January 1, 2022.***
Can we link our intranet or website to the VSP website?	Yes. To make it easy for members to find **vsp.com**, add the following code to your website: **vsp.com>VSP**.
What is my client ID number to register for the **Manage Your Plan** section?	You'll receive your client ID number with your welcome call or email. Each month's bill contains your client ID number, along with the active division and class number(s). Or, contact the Client Support Team at **800.216.6248** for your client ID number.

QUESTIONS	ANSWERS
What if a member is dissatisfied with a VSP network provider, or the materials received through the VSP benefit?	Our Member Promise Program guarantees complete member satisfaction with services received from a VSP network provider. If a member isn't happy with the services or products from a VSP network provider when using their VSP benefit, please have them contact VSP Member Services at **800.877.7195**.
Can members choose any eye care provider?	Yes. If VSP out-of-network coverage is included in your plan, members can obtain services from any provider they choose, including national or retail chains. Reimbursement for out-of-network services is according to a schedule with the same copays and limitations as services through VSP network providers. However, VSP can't guarantee satisfaction or extend discounts when using an out-of-network provider.
How do members collect reimbursement after visiting an out-of-network provider?	When services and/or materials are obtained from an out-of-network provider, members have two reimbursement choices: 1. Most out-of-network providers will submit a request for reimbursement on behalf of VSP members. This means members won't need to pay their entire bill up front and will only be responsible for paying applicable copays and any balance above their out-of-network schedule. 2. Members can pay the provider directly and submit a claim to VSP for reimbursement, using the following procedure: A. Visit the **Benefits and Claims** section of **vsp.com** to begin a claim. B. The member should fill out the claim form completely and submit an itemized receipt or statement that includes: • Doctor name or office name • Name of Patient • Date of Service • Each service received and the amount paid C. Submit claims online at **vsp.com** or by mail to: **VSP** **PO Box 495918** **Cincinnati, OH 45249-5918** Please note that claims for reimbursement must be filed within 12 months of the date of service. Members will be reimbursed according to the out-of-network reimbursement schedule.

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VSP is a registered trademark of Vision Service Plan. 115567 VCXA

See Well.
Be Well.



Welcome to VSP!

We believe in the connection between your vision and your overall health. As a VSP® Vision Care member, you get personalized care from a VSP network doctor at low out-of-pocket costs.

vsp vision care

Using your benefits is easy.

Create an account on **vsp.com** to view your in-network coverage, and find the VSP network doctor who's right for you.

With access to over $3,000 in savings, discover VSP Exclusive Member Extras at **vsp.com/offers** to maximize your benefits and save even more.

It's easy to find the frame brands that will maximize your benefits—just look for the VSP heart logo on the lens at your eye doctor's office.

Print a Member Vision Card—if you'd like one. There's no ID card necessary—just tell your provider you have VSP.

You deserve personalized, affordable vision care, delivered with your overall well-being in mind. We're committed to helping you experience a lifetime of healthy vision: **See Well. Be Well.®**

Your well-being is at the heart of everything we do.

Create an account, find your local VSP network doctor, and see your benefit at **vsp.com** today!

Questions? **vsp.com** | **800.877.7195** (TTY: 711)

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

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Classification: Public

Enrollment Form with Dependent Data

For employer internal use only. **DO NOT RETURN TO VSP.**

Employee last name, first name, middle initial: _____

Address: _____

Social Security Number: _____

Gender: ☐ male ☐ female Date of birth (month/date/year): _____

Effective Date of Coverage: _____

Type of coverage selected:
- ☐ employee only
- ☐ employee and one dependent
- ☐ employee and child(ren)
- ☐ employee and family
- ☐ waive coverage

*** Dependent Relationship**: S=spouse, C=child, H=handicapped child, T=student

dependent last name	dependent first name	gender	* Dependent Relationship	date of birth mm/dd/yyyy
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /

Employee Signature: _____

MRSD SAU#93 SCHOOL YEAR HEALTH COSTS 25/26

ADMINISTRATION/PRINCIPALS

HEALTH

OA10	TOTAL COST	DISTRICT 26 PAYS	EMPLOYEE 26 PAYS	
RX 10/20/45/3K		***81%***		Per pay period
SINGLE	$16,644.12	$13,481.74	$3,162.38	$121.63
2-PERSON	$33,288.24	$26,963.47	$6,324.77	$243.26
FAMILY	$44,939.16	$36,400.72	$8,538.44	$328.40
AB5	**TOTAL COST**	**DISTRICT 26 PAYS**	**EMPLOYEE 26 PAYS**	
RX 10/20/45/3K		***88%***		Per pay period
SINGLE	$16,736.16	$14,727.82	$2,008.34	$77.24
2-PERSON	$33,472.32	$29,455.64	$4,016.68	$154.49
FAMILY	$45,187.68	$39,765.16	$5,422.52	$208.56
AB20 IPDED	**TOTAL COST**	**DISTRICT 26 PAYS**	**EMPLOYEE 26 PAYS**	
RX 10/20/45/3K		***94%***		Per pay period
SINGLE	$15,511.08	$14,580.42	$930.66	$35.79
2-PERSON	$31,022.16	$29,160.83	$1,861.33	$71.59
FAMILY	$41,879.88	$39,367.09	$2,512.79	$96.65

2/25/2025

DENTAL

	TOTAL COST	DISTRICT 100% 26 P	EMPLOYEE 26 PAYS	
SINGLE	$606.36	$606.36	$0.00	$0.00
TWO PER	$1,171.56	$1,171.56	$0.00	$0.00
FAM	$2,112.36	$2,112.36	$0.00	$0.00

VSP VISION CARE

Plan C	TOTAL COST	EMPLOYEE 26 PAYS	
$10/$25			
SINGLE	116.16	116.16	4.47
EMPLOYEE +1	185.88	185.88	7.15
EMPLOYEE +CHI	189.72	189.72	7.3
FAMILY	305.88	305.88	11.76

MRSD SAU#93 SCHOOL YEAR HEALTH COSTS 25/26

IT; BTB; SAU OFFICE

HEALTH

OA10	TOTAL COST	DISTRICT 26 PAYS		EMPLOYEE 26 PAYS	
RX 10/20/45/3K		***81%***			Per pay period
SINGLE	$16,644.12	$13,481.74	$518.53	$3,162.38	$121.63
2-PERSON	$33,288.24	$26,963.47	$1,037.06	$6,324.77	$243.26
FAMILY	$44,939.16	$36,400.72	$1,400.03	$8,538.44	$328.40

AB5	TOTAL COST	DISTRICT 26 PAYS		EMPLOYEE 26 PAYS	
RX 10/20/45/3K		***88%***			Per pay period
SINGLE	$16,736.16	$14,727.82	$566.45	$2,008.34	$77.24
2-PERSON	$33,472.32	$29,455.64	$1,132.91	$4,016.68	$154.49
FAMILY	$45,187.68	$39,765.16	$1,529.43	$5,422.52	$208.56

AB20 IPDED	TOTAL COST	DISTRICT 26 PAYS		EMPLOYEE 26 PAYS	
RX 10/20/45/3K		***94%***			Per pay period
SINGLE	$15,511.08	$14,580.42	$560.79	$930.66	$35.79
2-PERSON	$31,022.16	$29,160.83	$1,121.57	$1,861.33	$71.59
FAMILY	$41,879.88	$39,367.09	$1,514.12	$2,512.79	$96.65

2/25/2025

DENTAL

	TOTAL COST	DISTRICT 90% 26 PAYS		EMPLOYEE 26 PAYS	
SINGLE	$606.36	$545.72	$20.99	$60.64	$2.33
TWO PER	$1,171.56	$1,054.40	$40.55	$117.16	$4.51
FAM	$2,112.36	$1,901.12	$73.12	$211.24	$8.12

VSP VISION CARE

Plan C		TOTAL COST	EMPLOYEE 26 PAYS		
$10/$25					
SINGLE		116.16	116.16	4.47	
EMPLOYEE +1		185.88	185.88	7.15	
EMPLOYEE +CHILDREN		189.72	189.72	7.3	
FAMILY		305.88	305.88	11.76	

MRSD SAU#93 SCHOOL YEAR HEALTH COSTS 25/26

NUTRITION; TITLE I

HEALTH

OA10	TOTAL COST	DISTRICT 21 PAYS		EMPLOYEE 21 PAYS	
RX 10/20/45		***81%***			Per pay period
SINGLE	$16,644.12	$13,481.74	$641.99	$3,162.38	$150.59
TWO PER	$33,288.24	$26,963.47	$1,283.97	$6,324.77	$301.18
FAM	$44,939.16	$36,400.72	$1,733.37	$8,538.44	$406.59
AB5 COPAY	**TOTAL COST**	**DISTRICT 21 PAYS**		**EMPLOYEE 21 PAYS**	
RX 10/20/45		***88%***			Per pay period
SINGLE	$16,736.16	$14,727.82	$701.32	$2,008.34	$95.64
TWO PER	$33,472.32	$29,455.64	$1,402.65	$4,016.68	$191.27
FAM	$45,187.68	$39,765.16	$1,893.58	$5,422.52	$258.22
AB20 IPDED	**TOTAL COST**	**DISTRICT 21 PAYS**		**EMPLOYEE 21 PAYS**	
RX10/20/45		***94%***			Per pay period
SINGLE	$15,511.08	$14,580.42	$694.31	$930.66	$44.32
TWO PER	$31,022.16	$29,160.83	$1,388.61	$1,861.33	$88.63
FAM	$41,879.88	$39,367.09	$1,874.62	$2,512.79	$119.66

2/25/2025

DENTAL

	TOTAL COST	DISTRICT 90% 21 PAYS		EMPLOYEE 21 PAYS	
SINGLE	$606.36	$545.72	$25.99	$60.64	$2.89
TWO PER	$1,171.56	$1,054.40	$50.21	$117.16	$5.58
FAM	$2,112.36	$1,901.12	$90.53	$211.24	$10.06

VSP VISION CARE

Plan C	TOTAL COST		EMPLOYEE 21 PAYS	
$10/$25				
SINGLE	116.16		116.16	5.53
EMPLOYEE +ONE	185.88		185.88	8.85
EMPLOYEE +CHILDI	189.72		189.72	9.03
FAMILY	305.88		305.88	14.57