North Middlesex Regional School District
Benefit Plans - FY 2020
6/1/19 - 5/31/20

Health Insurance (75/25 split)

Health Plan	Coverage	Monthly Total	Monthly Rate Employer	Monthly Rate Employee	24 pays	Employee Annual
Tufts EPO Advantage (HMO)	Family	$ 2,335.00	$ 1,751.25	$ 583.75	$ 291.88	$ 7,005.00
Plan # 16208-160	Individual	$ 860.00	$ 645.00	$ 215.00	$ 107.50	$ 2,580.00
Harvard Pilgrim EPO (HMO)	Family	$ 2,387.00	$ 1,790.25	$ 596.75	$ 298.38	$ 7,161.00
Plan # 287170006	Individual	$ 908.00	$ 681.00	$ 227.00	$ 113.50	$ 2,724.00
Harvard Pilgrim EPO (PPO)	Family	$ 5,188.00	$ 3,891.00	$ 1,297.00	$ 648.50	$ 15,564.00
Plan # 834490006	Individual	$ 1,965.00	$ 1,473.75	$ 491.25	$ 245.63	$ 5,895.00
Fallon Select Care (HMO)	Family	$ 1,877.00	$ 1,407.75	$ 469.25	$ 234.63	$ 5,631.00
Plan # 5550512	Individual	$ 703.00	$ 527.25	$ 175.75	$ 87.88	$ 2,109.00
Fallon Direct Care (HMO)	Family	$ 1,749.00	$ 1,311.75	$ 437.25	$ 218.63	$ 5,247.00
Plan # 5550511	Individual	$ 654.00	$ 490.50	$ 163.50	$ 81.75	$ 1,962.00

HSA Qualified Plans

Health Plan	Coverage	Monthly Total	Monthly Rate Employer	Monthly Rate Employee	24 pays	Employee Annual
Tufts HMO HSAQ	Family	$ 1,914.00	$ 1,435.50	$ 478.50	$ 239.25	$ 5,742.00
Plan # 54707-160	Individual	$ 705.00	$ 528.75	$ 176.25	$ 88.13	$ 2,115.00
Harvard Pilgrim HMO HSAQ	Family	$ 1,886.00	$ 1,414.50	$ 471.50	$ 235.75	$ 5,658.00
Plan # 747480006	Individual	$ 717.00	$ 537.75	$ 179.25	$ 89.63	$ 2,151.00
Fallon Select Care HMO HSAQ	Family	$ 1,539.00	$ 1,154.25	$ 384.75	$ 192.38	$ 4,617.00
Plan # 5550814	Individual	$ 576.00	$ 432.00	$ 144.00	$ 72.00	$ 1,728.00
Fallon Direct Care HMO HSAQ	Family	$ 1,434.00	$ 1,075.50	$ 358.50	$ 179.25	$ 4,302.00
Plan # 5550813	Individual	$ 536.00	$ 402.00	$ 134.00	$ 67.00	$ 1,608.00

Dental - Delta Dental

Delta Dental Plan	Coverage	Monthly Total		Monthly Rate Employee	24 pays	Employee Annual
Delta Dental Premier	Family	$ 97.00		$ 97.00	$ 48.50	$ 1,164.00
Plan # 009506-6343	Individual	$ 39.00		$ 39.00	$ 19.50	$ 468.00
Delta Dental PPO Plus Premier	Family	$ 134.00		$ 134.00	$ 67.00	$ 1,608.00
Plan # 009506-6344	Individual	$ 53.00		$ 53.00	$ 26.50	$ 636.00

Vision - EyeMed 7/1/19 - 6/30/20

EyeMed Group # 1022672	Coverage	Monthly Total		Monthly Rate Employee	24 pays	Employee Annual
Subscriber + Family		$ 21.60		$ 21.60	$ 10.80	$ 259.20
Subscriber + Child(Children)		$ 14.69		$ 14.69	$ 7.35	$ 176.28
Subscriber + Spouse		$ 13.96		$ 13.96	$ 6.98	$ 167.52
Subscriber		$ 7.34		$ 7.34	$ 3.67	$ 88.08

Updated 7/11/2019