NORTH ATTLEBORO PUBLIC SCHOOLS

BENEFITS CHECKLIST for plans beginning July 1, 2025, to June 30, 2026

Coverage to begin on the 1st of the month following date of hire.
***If a 3rd pay week occurs in a month, there will be no health insurance deduction for that week. (Bi-Weekly Deductions)**

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS HEALTH INSURANCE

If you elect to participate in the Health Insurance Program, you MUST complete the Enrollment Change Form to be submitted to the Insurance Carrier. Coverage to begin on the 1st of the month following date of hire. (Bi-Weekly Deductions)
***Note: 10 MONTH EMPLOYEES will pay an additional "catch-up" for July and August Premium (September through May)**

I am aware that I am responsible for paying the premium in full that is paid one month in advance of the effective date of coverage along with the bi-weekly premium.

PLAN TYPE:	INDIVIDUAL RATE	FAMILY RATE
_____(HMO) NETWORK BLUE NEW ENGLAND DEDUCTABLE PLAN	$127.19	$333.40
_____(PPO) BLUE CARE ELECT DEDUCTABLE PLAN	$227.95	$567.52
_____(HDHC) ACCESS BLUE NEW ENGLAND SAVER HIGH-DEDUCTIBLE PLAN	$101.75	$266.72

I currently have coverage with my previous employer which will end on _____

_____I am presently declining coverage

EYEMED VISION INSURANCE

If you elect to participate in the Vision Program, you MUST complete the Enrollment Change Form to be submitted to the Insurance Carrier. Coverage to begin on the 1st of the month following date of hire. (Bi-Weekly Deductions)
***Note: 10 MONTH EMPLOYEES will pay an additional two (2) mos. for July and August Premium (April through May)**

I am aware that I am responsible for paying the premium in full that is paid one month in advance of the effective date of coverage along with the bi-weekly premium.

PLAN TYPE:

_____ I would like to enroll in an EMPLOYEE ONLY Plan **($1.82)**

_____ I would like to enroll in an EMPLOYEE & SPOUSE Plan (**$3.10)**

_____ I would like to enroll in an EMPLOYEE PLUS ONE OR MORE CHILDREN **($3.19)**

_____ I would like to enroll in a FAMILY **($5.01)**

I currently have coverage with my previous employer which will end on _____

_____I am presently declining coverage

100% EMPLOYEE PAID BENEFITS

ALTUS DENTAL INSURANCE PLAN

If you elect to participate in the Dental Insurance Plan you MUST complete the Enrollment Form to be submitted to the Insurance Carrier. Coverage to begin on the 1st of the month following date of hire. (Bi-Weekly Deductions)
***Note: 10 MONTH EMPLOYEES will pay an additional two (2) mos. for July and August Premium (April through May)**

I am aware that I am responsible for paying the premium in full that is paid one month in advance of the effective date of coverage along with the bi-weekly premium.

_____ I would like to enroll in an Individual Plan **($18.04)**

_____ I would like to enroll in a Family Plan **($54.72)**

I currently have coverage under my previous employer, which will end on _____

_____ I am presently declining coverage

$1,500 Annual Maximum (in-network & out-of- network combined) ♦ $1,000 Elective Orthodontic Lifetime Maximum at 50% (to age 19) ♦ Deductible—Individual $50 / Family $150 ◊ Maximum Lifetime Cap Unlimited ♦ Dependent Coverage: Dependent children covered under a family plan are covered under these benefits up until the end of the month that they turn age 26.

BOSTON MUTUAL BASIC & VOLUNTARY TERM LIFE INSURANCE

Deductions are made on the 1st. pay of the month. If you elect to participate in the Life Insurance Program, you MUST complete the Enrollment Form to be submitted to the Insurance Carrier.
***Note: 10 MONTH EMPLOYEES will pay an additional two (2) mos. for July and August Premium in June**

_____I would like to enroll in the Basic Life Insurance Program ($10,000 coverage at $1.35 cost per month -> 25% Employee Cost) ■**Total Monthly Premium:** $5.40 ■**Town Monthly Cost** (75%): $4.05 ■**Employee Monthly Cost** (25%): $1.35

_____I am presently declining coverage (If you elect to decline coverage you MUST sign off on the Refusal of Insurance Form)

_____New Enhanced Term Life Insurance *(**MUST** be enrolled in the Basic Life Insurance Plan)

_____I am presently declining coverage

Life/AD&D Rates ***SEE ISSUE AGE OPTION***

Amount of Insurance Employee $_____Cost $_____

Dependent Life: Spouse $_____ Child (ren) $_____

(Employees **MUST** have coverage to insure spouse and /Or Children)

OTHER PLAN OFFERINGS

PLEASE CALL LIFE PLUS INSURANCE AGENCY, INC DIRECTLY AT 781.837.9222
rgoodson@hilbgroup.com

- Long Term Disability – payroll deduction only

PLEASE CALL COLOINAL LIFE, KIMBERLY CUNNINGHAM AT 401.596.1510 OR EMAIL AT KIMBERLY.CUNNINGHAM@COLONIALLIFESALES.COM

- Disability Insurance - provides a monthly benefit to replace your income if you are unable to work due to a covered disability. Choose from a variety of plans. Now Covers Mental Health! (post-tax)
- Accident Insurance - pays a range of benefits for simple and complex accidents. Great for the whole family. (Pre-tax)
- Medical Bridge - provides benefits to employees to help with the out-of-pocket expenses related to events such as hospital confinement, outpatient surgery, diagnostic tests and more. (Pre-tax)
- Critical Illness with Cancer - pays you a lump sum to help cover your out-of-pocket expenses if diagnosed with a critical illness, such as a heart attack, cancer or stroke. (Pre-tax)
- Whole Life Insurance - permanent life coverage - several plan options to select from to meet your needs and fit your budget. (Post-tax)

U.S. LEGAL SERVICES FAMILY DEFENDER

_____I would like to enroll in Family Defender coverage for **$18.75 per month**.

_____**I am presently declining coverage**

FLEXIBLE SPENDING ACCOUNT

If you elect to participate in the Flexible Spending Account you MUST complete the Enrollment Form to be submitted to Cafeteria Plan Advisors, Inc.

I am aware that my deductions are to be taken pre-tax under Section 125 Cafeteria Tax Plan.

_____I would like to enroll in FLEXIBLE SPENDING ACCT. **Administrative Fee $60.00 Per Year**

_____**I am presently declining coverage**

Employee Print Name:_____

Employee Signature:_____ **Date:**_____

SECRETARIES AND PARAPROFESSIONALS ONLY

The NAFT Secretarial & Paraprofessional collective bargaining agreements allow for employees covered under these agreements to have the following pay option: Pro-rate their salary over a twelve (12) month period. Notice of intent to receive pro-rated salary must be sent to payroll no later than July 1st preceding the new year.

Contact the Payroll Department, 508-643-2100 with your decision.

I understand and agree that if I owe the North Attleboro School District (NASD) any money (for unpaid benefits, etc.), at the time my employment ends, the NASD may recoup that money by deducting it from my last paycheck.

Signature: _____Date: _____