

2024 Health Insurance Pro-ration - Based on 19 Pay Periods

Cash in Lieu of Health Insurance		
9-Month Secretaries, Cooks, Nurses & Bus Drivers		
Based on 19 Pay Periods	BEFORE 7/1/2010	AFTER 7/1/2010
7.25-8 hrs/Day	\$419.36	\$110.40
6.25-7 hrs/Day	\$364.84	\$96.05
5.25-6 hrs/Day	\$314.51	\$82.80
4.25-5 hrs/Day	\$260.00	\$68.45
4 hrs/Day	\$209.68	\$55.20

Cash in Lieu of Health Insurance		
Paraprofessionals/Custodians		
Based on 19 Pay Periods	BEFORE 7/1/2008	AFTER 7/1/2008
7.25-8 hrs/Day	\$419.36	\$110.40
6.25-7 hrs/Day	\$364.84	\$96.05
5.25-6 hrs/Day	\$314.51	\$82.80

Health Partners \$2,000/\$4,000 Deductible Plan HSA Benefit \$1,527.36/\$3,022.08

School Year Employee				
		19 Pay Periods		Year
		Deduct/ Pay Period	Benefit/ Pay Period	
7.25 - 8 hrs/day	Family	\$ 506.01	\$ 644.02	\$ 21,850.56
	Single	\$ 33.48	\$ 473.74	\$ 9,637.20
6.25 - 7 hrs/day	Family	\$ 575.01	\$ 575.01	\$ 21,850.56
	Single	\$ 95.06	\$ 412.16	\$ 9,637.20
5.25 - 6 hrs/day	Family	\$ 575.01	\$ 575.01	\$ 21,850.56
	Single	\$ 151.91	\$ 355.31	\$ 9,637.20
4.25 - 5 hrs/day	Family	\$ 575.01	\$ 575.01	\$ 21,850.56
	Single	\$ 213.50	\$ 293.72	\$ 9,637.20
4 hrs/day	Family	\$ 575.01	\$ 575.01	\$ 21,850.56
	Single	\$ 253.61	\$ 253.61	\$ 9,637.20

Health Savings Account		
	Yearly	Per Pay Period
Family	\$3,022	\$ 159.06
Single	\$1,527	\$ 80.39

Health Partners \$3,500/\$7,000 Deductible Plan HSA Benefit \$2,175.40/\$4491.30
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School Year Employee				
		19 Pay Periods		Year
		Deduct/ Pay Period	Benefit/ Pay Period	
7.25 - 8 hrs/day	Family	\$ 468.01	\$ 595.65	\$ 20,209.44
	Single	\$ -	\$ 469.12	\$ 8,913.36
6.25 - 7 hrs/day	Family	\$ 531.83	\$ 531.83	\$ 20,209.44
	Single	\$ 60.99	\$ 408.14	\$ 8,913.36
5.25 - 6 hrs/day	Family	\$ 531.83	\$ 531.83	\$ 20,209.44
	Single	\$ 60.99	\$ 408.14	\$ 8,913.36
4.25 - 5 hrs/day	Family	\$ 531.83	\$ 531.83	\$ 20,209.44
	Single	\$ 178.27	\$ 290.86	\$ 8,913.36
4 hrs/day	Family	\$ 531.83	\$ 531.83	\$ 20,209.44
	Single	\$ 234.56	\$ 234.56	\$ 8,913.36

Health Savings Account		
	Yearly	Per Pay Period
Family	\$ 4,491.30	\$ 236.38
Single	\$ 2,175.40	\$ 114.49

2024 Health Insurance Pro-ration - Based on 20 Pay Periods

Cash In Lieu of Health Insurance

Employee must be covered by spouse's group health insurance plan and provide proof of insurance.

Health Partners \$2,000/ \$4,000 Deductible Plan

HSA Benefit \$1,527.36/\$3,022.08

Health Partners \$3,500/\$7,000 Deductible Plan

HSA Benefit \$2,175.40/\$4,491.30

Administration, Teachers - 20 Pay Periods

8 Hours Per Day

	Before	After
	7/1/2010	7/1/2010
Monthly (10 mo.)	\$ 796.78	\$ 419.52
Per Pay Period	\$ 398.39	\$ 209.76

Prorated Amounts

Option amount is based on contract FTE. For example .75 FTE is 75% of start date amount listed above.

Administration, Teachers - 20 Pay Periods

20 Pay Periods

	Deduct	Benefit	Month	Year
Family	\$ 72.11	\$ 1,020.42	\$ 2,185.06	\$ 21,850.56
Single	\$ 31.80	\$ 450.06	\$ 963.72	\$ 9,637.20

Prorated Amounts

Health insurance benefit is based on contract FTE.

Health Savings Account

	Yearly	Per Pay Period
Family	\$ 3,022.08	\$ 151.10
Single	\$ 1,527.36	\$ 76.37

Administration, Teachers - 20 Pay Periods

20 Pay Periods

	Deduct	Benefit	Month	Year
Family	\$ -	\$ 1,010.47	\$ 2,020.94	\$ 20,209.44
Single	\$ -	\$ 445.67	\$ 891.34	\$ 8,913.36

Prorated Amounts

Health insurance benefit is based on contract FTE.

Health Savings Account

	Yearly	Per Pay Period
Family	\$ 4,491.30	\$ 224.57
Single	\$ 2,175.40	\$ 108.77

2024 Health Insurance Pro-ration - Based on 24 Pay Periods

Cash In Lieu of Health Insurance			
12-Month Staff - 24 Pay Periods			
8 Hrs Per Day	Before	After	
	7/1/2010	7/1/2010	
Monthly	\$ 663.98	\$ 174.80	
Per Pay Period	\$ 331.99	\$ 87.40	
Prorated Amounts Per Pay Period			
7.25 - 8 Hr/Day	\$ 331.99	\$ 87.40	
6.25 - 7 Hr/Day	\$ 288.83	\$ 76.04	
5.25 - 6 Hr/Day	\$ 248.99	\$ 65.55	
4.25 - 5 Hr/Day	\$ 205.83	\$ 54.19	
4 Hr/Day	\$ 166.00	\$ 43.70	

Cash In Lieu of Health Insurance			
Custodians - 24 Pay Periods			
8 Hrs Per Day	Before	After	
	7/1/2008	7/1/2008	
Monthly	\$ 663.98	\$ 174.80	
Per Pay Period	\$ 331.99	\$ 87.40	
Prorated Amounts Per Pay Period			
7.25 - 8 Hr/Day	\$ 331.99	\$ 87.40	
6.25 - 7 Hr/Day	\$ 288.83	\$ 76.04	
5.25 - 6 Hr/Day	\$ 248.99	\$ 65.55	
4.25 - 5 Hr/Day	\$ 205.83	\$ 54.19	
4 Hr/Day	\$ 166.00	\$ 43.70	

Health Partners \$2,000/ \$4,000 Deductible Plan
HSA Benefit \$1,527.36/\$3,022.08

12-Month Staff, Custodians - 24 Pay Periods				
	24 Pay Periods		Month	Year
	Deduct	Benefit		
Family	\$60.09	\$850.35	\$1,820.88	\$21,850.56
Single	\$26.50	\$375.05	\$803.10	\$9,637.20
Prorated Amounts				
Health insurance benefit is based on contract FTE.				
Health Savings Account				
			Per Pay Period	
Family		\$3,022.08		\$ 125.92
Single		\$1,527.36		\$ 63.64

Cash In Lieu of Health Insurance
Employee must be covered by spouse's group health insurance plan and provide proof of insurance.

Prorated 12 Month Staff - 24 Pay Periods		
	Month	Year
Family	\$1,820.88	\$21,850.56
Single	\$803.10	\$9,637.20
Prorated Amounts Per Pay Period		
7.25 - 8 Hr/Day	Deduction	Benefit
Family	\$ 60.09	\$ 850.35
Single	\$ 26.50	\$ 375.05
6.25 - 7 Hr/Day	Deduction	Benefit
Family	\$ 170.63	\$ 739.81
Single	\$ 75.26	\$ 326.29
5.25 - 6 Hr/Day	Deduction	Benefit
Family	\$ 272.68	\$ 637.76
Single	\$ 120.26	\$ 281.29
4.25 - 5 Hr/Day	Deduction	Benefit
Family	\$ 383.22	\$ 527.22
Single	\$ 169.02	\$ 232.53
4 Hr/Day	Deduction	Benefit
Family	\$ 455.22	\$ 455.22
Single	\$ 200.78	\$ 200.78

Health Partners \$3,500/\$7,000 Deductible Plan
HSA Benefit \$2,175.40/\$4,491.30

12-Month Staff, Custodians - 24 Pay Periods				
	24 Pay Periods		Month	Year
	Deduct	Benefit		
Family	\$0.00	\$842.06	\$1,684.12	\$20,209.44
Single	\$0.00	\$371.39	\$742.78	\$8,913.36
Prorated Amounts				
Health insurance benefit is based on contract FTE.				
Health Savings Account				
			Per Pay Period	
Family		\$4,491.30		\$ 187.14
Single		\$2,175.40		\$ 90.64

Prorated 12 Month Staff - 24 Pay Periods		
	Month	Year
Family	\$1,684.12	\$20,209.44
Single	\$742.78	\$8,913.36
Prorated Amounts Per Pay Period		
7.25 - 8 Hr/Day	Deduction	Benefit
Family	\$ -	\$ 842.06
Single	\$ -	\$ 371.39
6.25 - 7 Hr/Day	Deduction	Benefit
Family	\$ 109.47	\$ 732.59
Single	\$ 48.28	\$ 323.11
5.25 - 6 Hr/Day	Deduction	Benefit
Family	\$ 210.52	\$ 631.55
Single	\$ 48.28	\$ 323.11
4.25 - 5 Hr/Day	Deduction	Benefit
Family	\$ 319.98	\$ 522.08
Single	\$ 141.13	\$ 230.26
4 Hr/Day	Deduction	Benefit
Family	\$ 421.03	\$ 421.03
Single	\$ 185.70	\$ 185.70



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-883-2177 or visit us at www.healthpartners.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: \$3,500 Individual, \$7,000 Family Out-of-network: \$7,000 Individual, \$14,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Services marked with * and benefits with no charge under What You Will Pay are not subject to <u>deductible</u>	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	In-network: \$3,500 Individual, \$7,000 Family Out-of-network: \$12,000 Individual, \$24,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premium</u> , balance-billed charges (unless <u>balanced billing</u> is prohibited), and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.healthpartners.com/OpenAccess or call 1-800-883-2177 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office Visit: 0% <u>coinsurance</u> Convenience Care: 0% <u>coinsurance</u> Virtuwell: No charge	Office Visit: 30% <u>coinsurance</u> Convenience Care: 30% <u>coinsurance</u> Virtuwell: Not covered	None
	<u>Specialist</u> visit	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	0% <u>coinsurance</u>	30% <u>coinsurance</u> at retail, mail not covered	31 day supply retail / 93 day supply mail order Preventive Drugs: Generic: \$0 copay*/prescription; Brand: \$0 mail copay*/prescription
	Formulary brand drugs	0% <u>coinsurance</u>		
	Non-formulary brand drugs	0% <u>coinsurance</u>	30% <u>coinsurance</u> at retail, mail not covered	None
	<u>Specialty drugs</u>	0% <u>coinsurance</u>		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Out-of-network services apply to the in-network deductible
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Out-of-network services apply to the in-network deductible
	<u>Urgent care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Out-of-network services apply to the in-network deductible
If you have a hospital	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
stay	Physician/surgeon fees	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Inpatient services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you are pregnant	Office visits	No charge	30% <u>coinsurance</u>	None
	Childbirth/delivery professional services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Childbirth/delivery facility services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Out-of-network: 15 visit limit/year
	<u>Habilitation services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Out-of-network: 15 visit limit/year
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	120 maximum days per confinement
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to one wig per year for Alopecia Areata
	<u>Hospice services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	No charge	30% <u>coinsurance</u>	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|-----------------------|------------------------|------------------------|
| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care (Adult) | • Private-duty nursing | • Weight loss programs |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|---------------------|-------------------------|--|
| • Acupuncture | • Hearing aids | • Non-emergency care when traveling outside the U.S. |
| • Bariatric surgery | • Infertility treatment | • Routine eye care (Adult) |
| • Chiropractic care | | |

Your Rights to Continue Coverage There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Your plan at: 1-800-883-2177, or the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 / 1-800-236-8517 for the state insurance department or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Your plan at: 1-800-883-2177, or the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 / 1-800-236-8517 for the state insurance department. Additionally, a consumer assistance program can help you file your appeal. Contact: the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 / 1-800-236-8517.

Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-398-9119.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-883-2177.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-883-2177.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-883-2177.

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* —————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall <u>deductible</u>	\$3,500
■ <u>Specialist coinsurance</u>	0%
■ <u>Hospital (facility) coinsurance</u>	0%
■ <u>Other coinsurance</u>	0%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,500

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$3,500
■ <u>Specialist coinsurance</u>	0%
■ <u>Hospital (facility) coinsurance</u>	0%
■ <u>Other coinsurance</u>	0%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,500

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$3,500
■ <u>Specialist coinsurance</u>	0%
■ <u>Hospital (facility) coinsurance</u>	0%
■ <u>Other coinsurance</u>	0%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

2024 Health Insurance Pro-ration - Based on 24 Pay Periods

Cash In Lieu of Health Insurance

Employee must be covered by spouse's group health insurance plan and provide proof of insurance.

Administration, Teachers - 24 Pay Periods

8 Hours Per Day

	Before 7/1/2010	After 7/1/2010
Monthly (12 mo.)	\$ 663.98	\$ 349.60
Per Pay Period	\$ 331.99	\$ 174.80

Prorated Amounts

Option amount is based on contract FTE. For example .75 FTE is 75% of start date amount listed above.

Health Partners \$2,000/ \$4,000 Deductible Plan

HSA Benefit \$1,527.36/\$3,022.08

Administration, Teachers - 24 Pay Periods

	24 Pay Periods		Month	Year
	Deduct	Benefit		

Family	\$ 60.09	\$ 850.35	\$ 1,820.88	\$ 21,850.56
Single	\$ 26.50	\$ 375.05	\$ 803.10	\$ 9,637.20

Prorated Amounts

Health insurance benefit is based on contract FTE.

Health Savings Account

	Yearly	Per Pay Period
Family	\$ 3,022.08	\$ 125.92
Single	\$ 1,527.36	\$ 63.64

Health Partners \$3,500/\$7,000 Deductible Plan

HSA Benefit \$2,175.40/\$4,491.30

Administration, Teachers - 24 Pay Periods

	24 Pay Periods		Month	Year
	Deduct	Benefit		

Family	\$ -	\$ 842.06	\$ 1,684.12	\$ 20,209.44
Single	\$ -	\$ 371.39	\$ 742.78	\$ 8,913.36

Prorated Amounts

Health insurance benefit is based on contract FTE.

Health Savings Account

	Yearly	Per Pay Period
Family	\$ 4,491.30	\$ 187.14
Single	\$ 2,175.40	\$ 90.64