PERCENTAGE OF PREMIUM CALCULATION CHART

Rates: 01/01/2018 THRU 06/30/2018

STATE OF NEW JERSEY - DEPARTMENT OF THE TREASURY

DIVISION OF PENSIONS AND BENEFITS

STATE HEALTH BENEFITS PLAN

For Health Benefit Contribution under Chapter 78,P.L. 2011

(Local Government Employees)

	SEHBP Premium Rate: NJDirect10	SEHBP Premium Rate: NJDir2030	Benecard Prescription Premium Rate
Single:	$914.87	$794.39	$324.10
Husband/Wife:	$1,829.74	$1,588.78	$738.35
Parent/Child:	$1,701.66	$1,477.57	$420.74
Parent/Children:	$1,701.66	$1,477.57	$749.09
Family:	$2,616.53	$2,271.96	$749.09

Calculate Premium Percentages		
1.	This is your combined premium amount for your **Medical Plan** and **Prescription Plans** at your selected Level of Coverage.	$
2.	Multiply the premium amount in box 1 by 12 to find your Annual Premium.	$
3.	Use the ***Percentage on the Premiums Sharing Chart*** for your Level of Coverage to find your Salary Range and Percentage of Premium amount.	%
4a.	**Calculate your Medical Plan and Prescription Plan Contribution:** Multiply Annual Premium by the Percentage Premium.	$
4b.	Divide the amount on 4a by 20 (pay periods) for 10-month or 24 (pay periods) for 12-month employees to find your Bi-weekly Medical Plan Contribution.	$
Calculate Minimum Required Contribution		
	Employees must pay *minimum* of 1.5% of Annual Salary	
5.	Enter your total Annual Salary.	$
6.	Multiply your Annual Salary by 1.5% (Salary x 0.015).	0.015
7.	This is your 1.5% Minimum Annual Percentage of Salary.	$
8.	Divide the Annual amount on line 7 by 20 (pay periods) or 24 (pay periods).	$
9.	This is the **Minimum** Monthy amount you are required to pay.	$
Your Health Benefits Contribution each pay period.		
10.	Enter the amount on Line 4b or Line 9, whichever is the larger amount. **This is your deduction per pay check.**	$

SEHBP AETNA Rate: Freedom 1525	
S:	$845.27
HW:	$1,690.54
PC:	$1,572.20
PCs:	$1,572.20
F:	$2,417.47

SEHBP Premium Rate: NJDir2035	
S:	$683.18
HW:	$1,366.36
PC:	$1,270.71
PCs:	$1,270.71
F:	$1,953.89

PREMIUM SHARING CHART P.L.2011 C.78

COVERAGE TYPE: BASE SALARY:		FAMILY	HUS/WIFE PARENT/ CHILD(REN)	SINGLE
Under	$20,000			4.50%
$20,000 -	$24,999	-		5.50%
Under	$25,000	3.00%	3.50%	5.50%
$25,000 -	$29,999	4.00%	4.50%	7.50%
$30,000 -	$34,999	5.00%	6.00%	10.00%
$35,000 -	$39,999	6.00%	7.00%	11.00%
$40,000 -	$44,999	7.00%	8.00%	12.00%
$45,000 -	$49,999	9.00%	10.00%	14.00%
$50,000 -	$54,999	12.00%	15.00%	20.00%
$55,000 -	$59,999	14.00%	17.00%	23.00%
$60,000 -	$64,999	17.00%	21.00%	27.00%
$65,000 -	$69,999	19.00%	23.00%	29.00%
$70,000 -	$74,999	22.00%	26.00%	32.00%
$75,000 -	$79,999	23.00%	27.00%	33.00%
$80,000 -	$84,999	24.00%	28.00%	34.00%
$85,000 -	$89,999	26.00%	30.00%	34.00%
$90,000 -	$94,999	28.00%	30.00%	34.00%
$95,000 -	$99,999	29.00%	30.00%	35.00%
$100,000 -	$104,999	32.00%	35.00%	35.00%
$105,000 -	$109,999	32.00%	35.00%	35.00%
$110,000	Over	35.00%	35.00%	35.00%

INSTRUCTIONS:

In Box 1 enter the total of the monthly health & prescription premium rate that corresponds with your coverage.
example: Single coverage: NJDirect10 $809.92 + Benecard $324.10 = $1,134.02.

Under the Premium Sharing Chart find your coverage & your salary range. Example: Your coverage Is Single, and your contracted salary is $48,000.0. Your percentage rate will be 14.00%.

Enter your percentage in Box 3. (14.00%)
In Box 5 enter your annual salary. ($48,400)

Complete worksheet as instructed.

Compare Box 4b and Box 9. Enter the larger amount in Box 10. This is the amount that will be the mandatory deduction from your salary each pay period.

ANNUAL RATES:

THE FOLLOWING IS FOR INFORMATIONAL PURPOSES

	Delta Dental *ANNUAL* Premium	Vision Serv. Plan *ANNUAL* Premium
Single:	$507.48	$189.24
Hus/Wife:	$856.44	$189.24
Parent/C:	$856.44	$189.24
Parent/Cs	$1,468.92	$189.24
Family:	$1,468.92	$189.24

Affordable Care Act NJDirect1500HD Monthly Rate	
S:	$952.86
P/C:	$1,772.32

Board of Education Pays 50%.