PERCENTAGE OF PREMIUM CALCULATION CHART

Rates effective from : 01/01/2020 through 06/30/2020

STATE OF NEW JERSEY - DEPARTMENT OF THE TREASURY

DIVISION OF PENSIONS AND BENEFITS

STATE HEALTH BENEFITS PLAN

For Health Benefit Contributions under NJ P.L. 2011, Chapter 78

(Local Government Employees)

NJ STATE HEALTH BENEFIT RATES (MONTHLY PREMIUMS)

	NJDIRECT 10	NJDIRECT 1525	NJDIRECT 2030	NJDIRECT 2035
Single:	$ 928.03	$ 857.42	$ 805.81	$ 693.01
Member/Spouse:	$ 1,856.06	$ 1,714.84	$ 1,611.62	$ 1,386.02
Family:	$ 2,654.17	$ 2,452.22	$ 2,304.62	$ 1,982.01
Parent/Child:	$ 1,726.14	$ 1,594.80	$ 1,498.81	$ 1,289.00

CALCULATE PREMIUM PERCENTAGES

STEP 1	Enter your combined premium amounts for your ***Medical Plan*** and ***Prescription Plan*** at your selected level of coverage.	$
STEP 2	Multiply the premium amount in box 1 by 12 = ***Annual Premium.***	$
STEP 3	Use the ***Percentage on the Premiums Sharing Chart*** below to find your level of coverage for your salary range & percentage of premium amount due..	%
STEP 4a	Calculate your ***Medical and Prescription Plan*** Contribution: Multiply the Annual premium (Step 2) by the percentage premium rate (Step 3).	$
STEP 4b	Divide the amount on Step 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: 1.5% of annual salary

STEP 5	Enter your total Contracted Annual Salary.	$
STEP 6	Multiply your Contracted Annual Salary by 1.5% (annual salary x 0.015).	0.015
STEP 7	This is your 1.5% ***Minimum Annual Percentage of Salary*** .	$
STEP 8	Divide amount on line 7 by 20 or 24 ***(pays-10/12 month)*** . ***Minimum pay requiremt.***	$

YOUR HEALTH BENEFITS CONTRIBUTION EACH PAY PERIOD

STEP 9	Enter the amount on line 4b or Line 8, whichever is the larger amount. ***This is your Employee's Share of Premium Deduction due per pay check*** .	$

Employee's Share	Bd of Ed pays 50% of premium	AFFORDABLE CARE ACT NJDIRECT 1500HD
$ 442.80	Single:	$ 885.59
$ 823.60	Parent/Child:	$ 1,647.20

Benecard PBF Prescription Monthly Premium Rates	
Single:	$ 324.10
Member/Spouse:	$ 738.35
Parent/Child:	$ 420.74
Parent/Children:	$ 749.09
Family:	$ 749.09

SEHBP NO LONGER OFFERS AETNA 1525. THE PLAN HAS BEEN REPLACED WITH NJDIRECT1525

PREMIUM SHARING CHART

		MEMBER/SPOUSE		
		FAMILY	PARENT/CHILD	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%

THERE IS NO CHARGE TO EMPLOYEES FOR THE FOLLOWING COVERAGE. IT IS FOR INFORMATIONAL PURPOSES ONLY:

	DELTAL DENTAL MONTHLY PREMIUM RATES
Single:	$ 43.14
Member/Spouse:	$ 72.80
Parent/Child:	$ 72.80
Parent/Children:	$ 124.86
Family:	$ 124.86

	VSP Vision Monthly Rates
Flat Rate for all:	$ 15.77