PERCENTAGE OF PREMIUM CALCULATION CHART

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)

Rates effective from : 07/01/2020 through 12/31/2020

NJ STATE HEALTH BENEFIT RATES (MONTHLY PREMIUMS)

	NJDIRECT10 OPTUMRx	NJDIRECT1525 OPTUMRx	NJDIRECT2030 OPTUMRx	NJDIRECT2035 OPTUMRx
Single:	$ 1,053.23	$ 969.11	$ 917.50	$ 793.54
Member/Spouse:	$ 2,106.46	$ 1,938.22	$ 1,835.00	$ 1,587.08
Family:	$ 3,012.24	$ 2,771.65	$ 2,624.05	$ 2,269.53
Parent/Child:	$ 1,959.01	$ 1,802.54	$ 1,706.55	$ 1,475.99

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*** .	

Rx RATE IS INCLUDED IN ABOVE LISTED MONTHLY PREMIUMS	
Single:	$ 171.50
Member/Spouse:	$ 343.00
Family:	$ 490.49
Parent/Child:	$ 318.99

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

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

PREMIUM SHARING CHART

ANNUAL SALARY	FAMILY	MEMBER/SPOUSE 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