

Perth Amboy Board of Education

ADMINISTRATION HEADQUARTERS BUILDING

178 Barracks Street

Perth Amboy, New Jersey 08861

Tel: (732) 376-6200 Fax: (732) 638-1004



Derek J. Jess
School Business Administrator/
Board Secretary

HEALTH BENEFITS COVERAGE: 2019-2020 SCHOOL YEAR

Your health insurance coverage will begin on the first day of your contractual employment. Employees are eligible for Medical (*Aetna*), Prescription (*Benecard*), Dental (*Delta Dental*) and Vision (*VSP*) coverage.

Please complete, sign and return this form along with the attached enrollment form to the Benefits Department as soon as possible. **If we do not receive your form within thirty-one (31) days of your hire date, the insurance companies will not accept you into their program.**

Salary Threshold	Single	Family
Less Than \$20,000	1.5%	1.5%
\$20,000 - \$29,999	2.3%	3.5%
\$30,000 - \$39,999	2.9%	4.0%
\$40,000 - \$49,999	2.6%	4.3%
\$50,000 - \$59,999	3.7%	6.4%

Salary Threshold	Single	Family
\$60,000 - \$69,999	4.2%	7.9%
\$70,000 - \$79,999	4.3%	8.9%
\$80,000 - \$89,999	3.9%	8.4%
\$90,000 - \$99,999	3.7%	8.6%
More Than \$100,000	3.7%	8.6%

To estimate your required contribution, (1) multiply your base salary by the percentage corresponding to your salary threshold; that is your yearly contribution. (2) If you are a 10 month employee, divide your yearly contribution by 20 to calculate your per paycheck cost. If you are a 12 month employee, divide your yearly contribution by 24.

*****If you are a 10 month employee and are making changes between the months of August through June, or are a newly appointed staff member hired on or after September 1st, divide your yearly cost by 24 to calculate your per paycheck cost.*****

$$\begin{array}{ccccccc} \$ & \underline{\hspace{2cm}} & \times & \underline{\hspace{2cm}} & = & \$ & \underline{\hspace{2cm}} & \div & \underline{\hspace{2cm}} & = & \$ & \underline{\hspace{2cm}} \\ & \text{Your Annual Salary} & & \% \text{ Contribution} & & \text{Yearly Cost} & & 20 \text{ or } 24 & & & \text{Per Paycheck Cost} \end{array}$$

Please indicate the coverage you wish to receive:

- Single Coverage**
- _____ POS II Plan
- _____ POS Plan
- _____ PPO Plan

- Family Coverage:**
- _____ POS II Plan
- _____ POS Plan
- _____ PPO Plan

Date

Employee's Signature

Print Name