# Perth Amboy Board of Education

## ADMINISTRATION HEADQUARTERS BUILDING

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Perth Amboy, New Jersey 08861
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**Michael LoBrace**
School Business Administrator/
Board Secretary

## HEALTH BENEFITS COVERAGE: 2022-2023 SCHOOL YEAR

Your health insurance coverage will begin on the first day of your contractual employment.  Employees are eligible for Medical and Prescription *(Aetna),* 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.  **<u>*NEW EMPLOYEES: 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.*</u>**

| 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 <u>August through June</u>, or are a newly appointed staff member <u>hired on or after September 1<sup>st</sup></u>, divide your yearly cost by 24 to calculate your per paycheck cost.\*\*\***

$_____$  x  $_____$  = $_____$ ÷ $_____$ = $_____$

      Your Annual Salary           % Contribution           Yearly Cost         20 or 24    Per Paycheck Cost

Please indicate the coverage you wish to receive:

☐ **<u>Single Coverage</u>**

_____ POS II Plan

_____ POS Plan

_____ PPO Plan

☐ **<u>Family Coverage</u>:**

_____ POS II Plan

_____ POS Plan

_____ PPO Plan

_____     _____     _____

Date                   Employee's Signature               Print Name