Health Insurance Premiums - 2025 Employee Contributions

PREMIUM EQUIVALENTS FOR 2025

AETNA OPEN ACCESS PPO

CONTRACT TYPE	MEDICAL MONTH	RX MONTH	DENTAL MONTH	VISION MONTH	TOTAL MONTH	ANNUAL PREMIUMS
SINGLE	$ 1,020.83	$ 313.87	$ 22.47	$ 9.26	$ 1,366.43	**$ 16,397.16**
PARENT/CHILD	$ 2,011.37	$ 441.33	$ 39.01	$ 9.26	$ 2,500.97	**$ 30,011.64**
FAMILY	$ 2,817.82	$ 739.93	$ 62.62	$ 9.26	$ 3,629.63	**$ 43,555.56**
SINGLE 65+	$ 946.73	$ 313.87	$ 22.47	$ 9.26	$ 1,292.33	**$ 15,507.96**
PARENT/CHILD 65+	$ 1,865.38	$ 441.33	$ 39.01	$ 9.26	$ 2,354.98	**$ 28,259.76**
FAMILY 65+	$ 2,613.23	$ 739.93	$ 62.62	$ 9.26	$ 3,425.04	**$ 41,100.48**

AETNA CHOICE POS II

CONTRACT TYPE	MEDICAL MONTH	RX MONTH	DENTAL MONTH	VISION MONTH	TOTAL MONTH	ANNUAL PREMIUMS
SINGLE	$ 883.42	$ 313.87	$ 22.47	$ 9.26	$ 1,229.02	**$ 14,748.24**
PARENT/CHILD	$ 1,740.65	$ 441.33	$ 39.01	$ 9.26	$ 2,230.25	**$ 26,763.00**
FAMILY	$ 2,438.49	$ 739.93	$ 62.62	$ 9.26	$ 3,250.30	**$ 39,003.60**

AETNA OPEN ACCESS AETNA SELECT

CONTRACT TYPE	MEDICAL MONTH	RX MONTH	DENTAL MONTH	VISION MONTH	TOTAL MONTH	ANNUAL PREMIUMS
SINGLE	$ 729.05	$ 313.87	$ 22.47	$ 9.26	$ 1,074.65	**$ 12,895.80**
PARENT/CHILD	$ 1,436.46	$ 441.33	$ 39.01	$ 9.26	$ 1,926.06	**$ 23,112.72**
FAMILY	$ 2,012.35	$ 739.93	$ 62.62	$ 9.26	$ 2,824.16	**$ 33,889.92**

DENTAL & VISION	ONLY - Full Year Rate
SINGLE	$ 380.76
P/C	$ 579.24
FAMILY	$ 862.56

Calculating your share: Take the annual premium for the plan you have and multiply it by the percentage that matches your salary & plan type. That figure should be divided by 26 pays for your bi-weekly contribution.

CHAPTER 78 CONTRIBUTION RATES

********CONTRACT TYPE*********

Salary Ranges	SINGLE	PARENT/CHILD	FAMILY
Less than 20,000	4.5%	3.5%	3%
20,000 - 24,999.99	5.5%		
Less than 25,000			
25,000 - 29,999.99	7.5%	4.5%	4%
30,000 - 34,999.99	10%	6%	5%
35,000 - 39,999.99	11%	7%	6%
40,000 - 44,999.99	12%	8%	7%
45,000 - 49,999.99	14%	10%	9%
50,000 - 54,999.99	20%	15%	12%
55,000 - 59,999.00	23%	17%	14%
60,000 - 64,999.99	27%	21%	17%
65,000 - 69,999.99	29%	23%	19%
70,000 - 74,999.99	32%	26%	22%
75,000 - 79,999.99	33%	27%	23%
80,000 - **84,999.99**	**34%**	28%	24%
80,000 - **94,999.99**		***NOTES BELOW***	***NOTES BELOW***
85,000 - **89,999.99**			**26%**
85,000 - **99.999.99**	***NOTES BELOW***	**30%**	***NOTES BELOW***
90,000 - **94,999.99**			**28%**
95,000 - **99,999.99**			**29%**
95,000 **and over**	**35%**	***NOTES BELOW***	***NOTES BELOW***
100,000 **and over**		**35%**	
100,000 - **109,999.99**			**32%**
110,000 **and over**			**35%**

NOTES: for $80,000 and over, ranges are grouped differently.

File location: Drive T - Chapter 78 - 2025 Employee Contributions for Health Insurance Plans

Please note that the Township's Prescription & Dental Plans are remaining with Horizon

TOWNSHIP OF NORTH BERGEN

Health Insurance Premiums - 2024 Employee Contributions

PREMIUM EQUIVALENTS FOR 2024

HORIZON TRADITIONAL PLAN

CONTRACT TYPE	MEDICAL MONTH	RX MONTH	DENTAL MONTH	VISION MONTH	TOTAL MONTH	ANNUAL PREMIUMS
SINGLE	$ 1,020.83	$ 313.87	$ 22.47	$ 9.26	$ 1,366.43	$ 16,397.16
PARENT/CHILD	$ 2,011.37	$ 441.33	$ 39.01	$ 9.26	$ 2,500.97	$ 30,011.64
FAMILY	$ 2,817.82	$ 739.93	$ 62.62	$ 9.26	$ 3,629.63	$ 43,555.56
SINGLE 65+	$ 946.73	$ 313.87	$ 22.47	$ 9.26	$ 1,292.33	$ 15,507.96
PARENT/CHILD 65+	$ 1,865.38	$ 441.33	$ 39.01	$ 9.26	$ 2,354.98	$ 28,259.76
FAMILY 65+	$ 2,613.23	$ 739.93	$ 62.62	$ 9.26	$ 3,425.04	$ 41,100.48

HORIZON DIRECT ACCESS PLAN

CONTRACT TYPE	MEDICAL MONTH	RX MONTH	DENTAL MONTH	VISION MONTH	TOTAL MONTH	ANNUAL PREMIUMS
SINGLE	$ 883.42	$ 313.87	$ 22.47	$ 9.26	$ 1,229.02	$ 14,748.24
PARENT/CHILD	$ 1,740.65	$ 441.33	$ 39.01	$ 9.26	$ 2,230.25	$ 26,763.00
FAMILY	$ 2,438.49	$ 739.93	$ 62.62	$ 9.26	$ 3,250.30	$ 39,003.60

HORIZON OMNIA PLAN

CONTRACT TYPE	MEDICAL MONTH	RX MONTH	DENTAL MONTH	VISION MONTH	TOTAL MONTH	ANNUAL PREMIUMS
SINGLE	$ 729.05	$ 313.87	$ 22.47	$ 9.26	$ 1,074.65	$ 12,895.80
PARENT/CHILD	$ 1,436.46	$ 441.33	$ 39.01	$ 9.26	$ 1,926.06	$ 23,112.72
FAMILY	$ 2,012.35	$ 739.93	$ 62.62	$ 9.26	$ 2,824.16	$ 33,889.92

DENTAL & VISION	ONLY - Full Year Rate
SINGLE	$ 380.76
P/C	$ 579.24
FAMILY	$ 862.56

Calculating your share: Take the annual premium for the plan you have and multiply it by the percentage that matches your salary & plan type. That figure should be divided by 26 pays for your bi-weekly contribution.

CHAPTER 78 CONTRIBUTION RATES

********CONTRACT TYPE*********

Salary Ranges	SINGLE	PARENT/CHILD	FAMILY
Less than 20,000	4.5%	3.5%	3%
20,000 - 24,999.99	5.5%		
Less than 25,000			
25,000 - 29,999.99	7.5%	4.5%	4%
30,000 - 34,999.99	10%	6%	5%
35,000 - 39,999.99	11%	7%	6%
40,000 - 44,999.99	12%	8%	7%
45,000 - 49,999.99	14%	10%	9%
50,000 - 54,999.99	20%	15%	12%
55,000 - 59,999.00	23%	17%	14%
60,000 - 64,999.99	27%	21%	17%
65,000 - 69,999.99	29%	23%	19%
70,000 - 74,999.99	32%	26%	22%
75,000 - 79,999.99	33%	27%	23%
80,000 - **84,999.99**	**34%**	28%	24%
80,000 - **94,999.99**		*NOTES BELOW*	*NOTES BELOW*
85,000 - **89,999.99**			**26%**
85,000 - **99.999.99**	*NOTES BELOW*	**30%**	*NOTES BELOW*
90,000 - **94,999.99**			**28%**
95,000 - **99,999.99**			**29%**
95,000 **and over**	**35%**	*NOTES BELOW*	*NOTES BELOW*
100,000 **and over**		**35%**	
100,000 - **109,999.99**			**32%**
110,000 **and over**			**35%**

NOTES: for $80,000 and over, ranges are grouped differently.

File location: Drive T - Chapter 78 - 2024 Employee Contributions for Health Insurance Plans

TOWNSHIP OF NORTH BERGEN