PATERSON PUBLIC SCHOOLS

Preparing All Children for College and Career

Employee Benefits Enrollment Guide

Paterson Public Schools is pleased to welcome you as a new employee and looks forward to your first day of employment.

The benefits you may be eligible for as an employee of Paterson Public Schools are extensive. We have compiled some benefits information materials for you to review when making your benefit plan selections.

Please contact the Health Benefits Office at the numbers below to make an appointment to complete your Health Benefits Package.

Mrs. Lynette Gonzalez, Director of Employee Services 973-321-0745
Mrs. Marcel Javier, Supervisor of Staff Attendance, Health Benefits, and Pension 973-321-0743
Ms. Esther Boone, Pensions 973-321-0603
Mrs. Gleny Gaines, Health Benefits 973-321-0827
Mrs. Millie Torres, Health Benefits 973-321-2314
Ms. Maria Cobian, Staff Attendance 973-321-0975
Mrs. Sharon Barbaro, Staff Attendance 973-321-2310

You will have **10 business days from your date of hire** to personally return all properly completed and signed enrollment forms to:

Human Resource Services - Health Benefits
90 Delaware Ave., 3* Floor, Paterson, NJ 07503

Please regularly check your Paterson Public Schools e-mail account for official notifications concerning your health benefits.

Please be Advised: Mid-year new hire's (10-month employees ONLY) will owe for Health Benefits contributions for the months of July & August. Back health benefits contributions will be deducted from your paycheck, accordingly.

I have received my Employee Health Benefits Packet, including applications and benefit summaries. **I understand that my *failure* to return the enrollment applications or waiver forms within the 60-day time period will result in me being defaulted to the NJ Educator's medical and prescription plan.** I understand that my next opportunity to waive benefits or elect dental or vision coverage will be during open enrollment. Open Enrollment is during the month of October for an enrollment effective date of January 1 of the next following year. If any additional open enrollment periods are held, I understand that I will be notified via email.

*Signature*_____ *Date*_____

Print Name_____ School/Location_____

Preparing All Children for College and Career
Together We Can

Employee Benefits Checklist

Please retain this sheet for your personal records.

Please provide the following appropriate items for yourself and all eligible dependents (Spouse/Civil Union Partner, Natural/Adopted/Step-Child(ren), Legal Ward/Guardianship Child(ren):

☐	Completed Health Benefits Enrollment Form. If you have selected the Flagship/DeltaCare dental plan you have listed a dentist office from the booklet provided. If not Delta Dental will select one for you.
☐	**Birth Certificate(s),** Current Passport or Naturalization I.D. for yourself and each dependent.
☐	**Social Security card(s)** for yourself and each dependent.
☐	***Marriage Certificate*** with raised seal or NJ Civil Union Certificate or valid certification from another jurisdiction that recognizes same sex civil unions
☐	Legal documents of all adoptions and court orders.

Effective Date of Coverage
Medical and RX:____/____/_____
Dental and Vision:___/___/_____

www.HorizonBlue.com/members
www.caremark.com
www.deltadentalnj.com
www.vsp.com

My Plan Selection	
Medical	
Prescription	
Dental	
Flagship Dental Office	
Vision	

Health Benefits Provider Contact Information

State of New Jersey Pensions and Benefits	Client Services 609-292-7524 Help Desk 609-777-0534 www.state.nj.us/treasury/pensions/mbosregister.htm
Horizon Blue Cross Blue Shield	1-800-355-2583 www.horizonblue.com
CVS Caremark	1-888-964-0131 www.caremark.com
Vision Services Plan	Client Services 800-877-7195 www.vsp.com
Delta Dental	**Flagship (Deltacare)** Client Services 800-722-3524 Premier/Preferred PPO Client Services 800-335-8265 www.deltadentalnj.com

Retirement Plans/Disability Insurance Vendors	
Customer Support	866-294-7950
AXA Equitable -Robert Waldron	732-452-7275
Great American Life Insurance Company Sandy Kessler	973-628-1818
Lincoln Financial Group - Anthony Cingire	201-556-4598
Metlife - Mike Stieglitz	973-328-1825
Sun America Life Insurance Co. - Michael Ballan	201-398-0144
Valic - Patrick	201-388-7039
Valic - Kathryn Jones	917-891-1714
Victory Capital Holdings Inc. - Patricia Gallegos	800-531-8292
Retirement Manager	1-866-294-7950 1-888-889-9916 https://www.myretirementmanager.com

Disability Insurance/Life Insurance
Cindy Cooper 732-918-2000 ext. 25
Prudential Disability Insurance 800-727-3414
New hires have 90 days to enroll and district employees can enroll at any time must go through a special Program with Prudential. **Open enrollment** is every **3 years**, last open enrollment was in 2015/2016 school year. To apply for Prudential Disability Insurance you must be a NJEA member.

AFLAC Disability Insurance
PEA Members: Disability, Cancer/Critical Illness, Hospital, Accident.
Non-PEA Employees: Disability, Cancer/Critical Illness, Hospital, Accident, Life, Dental, Vision.

Gina Purazzo PO Box 477 Port Monmouth, NJ 07758 Gina.Purazzo@gmail.com	732-444-8446
Jonathan Torres Aflac agent Jonathan_Torres@us.aflac.com	973-944-0882
Customer Service	800-992-3522
Claims Fax	877-442-3522

Your policy number must be on all the documents. To order a copy of your policy call 800-842-3522.

Teacher's Protective Mutual Disability Insurance Ralph Rudnick	201-797-3699
Boston Mutual Life Insurance Co. Jami Woodworth Jami_Woodworth@bostonmutual.com	1-800-669-2668 Ext.583
Credit Union: North Jersey Federal Credit Union **Payroll Department:** Debbie Shipp	973-321-0804 www.njfcu.org

Active Premiums

Prescription Drug - CVS NJ Educator's Plan and Garden State Plan - Rates Effective January 2022 - December 2022	
RX Deductible	None
Out of Pocket Maximum	$1,600/$3,200
Retail Generic- Up to 34 day supply	$5
Retail Brand- Up to 34 day supply	$10
Mail Order-Up to 90 day	$10/$20
Formulary	Closed
Mandatory Generic	Yes
Dependent child eligible-birth to 12/31 of 26th birth year	

Vision - VSP - Rates effective January 1, 2018 - December 31, 2021 *PPS pays entire premium for this coverage.				Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Active Group #	04112951 - Division 0001	Plan A -	$20 copay	$0.00	$0.00	$0.00	$0.00
Active Group #	04112951 - Division 0002	Plan B -	$10 copay	$0.00	$0.00	$0.00	$0.00
Dependent child eligible-birth to 12/31 of 23th birth year							

Dental - Delta Dental - Rates effective January 1, 2020 - December 31, 2020 *PPS pays entire premium for this coverage.				Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Active Group #	7456-0001		Premier - $2,000 ortho max	$0.00	$0.00	$0.00	$0.00
Active Group #	7456-0002		Premier - $1,000 ortho max	$0.00	$0.00	$0.00	$0.00
Active Group #	7456-6001		PPO - $2,000 ortho max	$0.00	$0.00	$0.00	$0.00
Active Group #	7456-6002		PPO - $1,000 ortho max	$0.00	$0.00	$0.00	$0.00
Active Group #	7456-9001-467		Flagship - $800 ortho copay	$0.00	$0.00	$0.00	$0.00
Active Group #	7456-9003-1047		Flagship - $1,000 ortho copay	$0.00	$0.00	$0.00	$0.00
Dependent child eligible-age 2 to 24th birthday							

***To calculate the approximate amount to be deducted per paycheck, for the NJ Educator's Plan, please see the medical calculator excel sheet attached in the email provided to you.**

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ENROLLMENT FORM FOR NEW HIRES AFTER 7/1/2020

	Date of Hire:

Reason for change in enrollment is due to:

☐ New Enrollment ☐ Adding Dependents ☐ Loss of Coverage ☐ Other_____

☐ Open Enrollment ☐ Deleting Dependents ☐ Return from Leave of Absence Date of Return:___/___/___

Employee Name (Last, First)	Date of Birth	Social Security #	Gender
			M( ) F( )

Street Address	City	State Zip Code	Home Phone
			( )

NJ Educators Plan Medical & Prescription	☐ Employee only	☐ Employee plus spouse	☐ Employee plus children	☐ Employee plus family	☐ I am WAIVING medical and prescription coverage.
Garden State Plan Medical & Prescription	☐ Employee only	☐ Employee plus spouse	☐ Employee plus children	☐ Employee plus family	

Delta Dental: **Effective Date:**_____

Premier 7456-0001	☐	Premier 7456-0002	☐	**Choose Level of Coverage :**
Preferred PPO 7456-6001	☐	Preferred PPO 7456-6002	☐	(1) ☐ Employee only
Flagship 7456-9001	☐	Flagship 7456-9003	☐	(2) ☐ Employee plus spouse

If choosing DeltaCare/Flagship, please list Dentist and Office Number.

1._____

Office#:_____

(3) ☐ Employee plus children

(4) ☐ Employee plus family

☐ I am WAIVING DENTAL coverage.

Vision Service Plan: **Effective Date:**_____

		Choose Level of Coverage :
VSP-A	☐	(1) ☐ Employee only
VSP-B	☐	(2) ☐ Employee plus spouse
		(3) ☐ Employee plus children
		(4) ☐ Employee plus family

☐ I am WAIVING VISION coverage.

Dependent Information: List all eligible dependents and attach required proof of dependency documents. **Any dependents not added will be removed.**

Eligible Dependents Last Name, First Name	Social Security No.	Relationship	Birth Date	Gender

EMPLOYEE CERTIFICATION---I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I also understand that there is no guarantee of continuous participation by medical providers, either doctors or facilities, in the plans. If either my physician or medical center terminates participation in my selected plan, I must select another doctor or medical center participating in that plan to receive the "in-network" benefit. I authorize any hospital, physician, or health care provider to furnish my medical plan or its assignee with such medical information about myself or my covered dependents as the assignee may require

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties pursuant to N.J.S.A. 17:33A-6c.

Employee Signature: **Date:**___/___/___

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Coverage Waiver Certification

Please check the appropriate box:

☐ I elect to waive medical coverage and understand that in order to waive coverage through Paterson Public Schools; I must document my coverage under another plan.

☐ I elect to waive medical coverage. My spouse/domestic partner is a Paterson Public Schools' employee and my medical coverage is through their plan.

PPS Employee Information

Employee's Name (Last, First)

Employee's Social Security Number

Employee's Signature

Date

Level of Coverage

☐ **Single** (or covered by parent's insurance. Proof attached)

☐ **Member + Spouse** (Proof attached)

☐ **Parent + Child(ren)** (Proof attached)

☐ **Family** (Proof attached)

Policy Holder Information

Policy Holder's Name (Last, First)

Policy Holder's Medical Insurance Company

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Enrollment Form: Flexible Spending Account(s)

Optional

Plan Start Date January 1 **Plan End Date December 31**

Today's Date:	Date of Hire:	Effective Date:

Reason for change in enrollment is due to:

☐ New Enrollment ☐ Adding Dependents ☐ Loss of Coverage ☐ Other_____

☐ Open Enrollment ☐ Return from Leave of Absence Date of Return: ____/____/____

Employee Name (Last, First)	Date of Birth	Social Security #	Gender
			☐ Male ☐ Female

Street Address	City	State	Zip Code	Home Phone
				( )

FLEXIBLE SPENDING ACCOUNTS:

Maximum Annual Amount for Medical Healthcare FSA is $2,650
Maximum Annual Amount for Dependent Care FSA is $5,000
Number of Pay Periods is based on 20 pay periods annually unless start date is after January 1

	Per Pay Deduction	Pay Periods	Annual Election:
Health Care FSA	$ _____	x 20	= $ _____
Dependent Care FSA	$ _____	x 20	= $ _____

AUTHORIZATION & ACKNOWLEDGEMENT:

I understand that:

- I authorize my employer to reduce my compensation by the amount specified. This election will expire at the end of the plan year, and I must make a new election each year.
- I am not permitted to revoke or change my elections during the plan year unless the change is due to and in accordance with certain recognized IRS regulations for change in status events.
- I must report any administrative errors to my payroll administrator or human resources department within 10 days of my first payroll deduction of the plan year.
- Funds left in my Health Care and/or Dependent Care Account at the close of the plan year will be forfeited.
- I also understand that if I or my spouse participates in a Health Savings Account (HSA), eligible medical expenses under the Health Care Flexible Spending Account may be limited and/or will affect eligibility to make HSA contributions.

EMPLOYEE CERTIFICATION---I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties pursuant to N.J.S.A. 17:33A-6c.

Employee Signature: _____ Date: _____

For employer use:

Effective date of coverage: _____ First payroll deduction will be on _____, 20____