MOUNT HOLYOKE

# Full Time Employee -Benefits Rates 2022-2023

| Plan | Level of Coverage | Monthly Premium | College Shared Monthly Cost* | Employee Shared Monthly Cost | For comparison 21/22 Monthly Employee Share | $ Increase |
|---|---|---|---|---|---|---|
| **HMO Blue** | Individual | $845.46 | $634.10 | $211.37 | **$185.57** | $25.80 |
| | Ind + Child(ren) | $1,819.77 | $1,328.43 | $491.34 | **$431.38** | $59.96 |
| | Ind + Partner | $2,191.99 | $1,600.15 | $591.84 | **$519.61** | $72.23 |
| | Family | $2,233.35 | $1,630.35 | $603.00 | **$529.41** | $73.59 |
| **HMO Blue New England (Value HMO) $1,000 deductible** | Individual | $741.69 | $634.10 | $107.60 | **$94.47** | $13.13 |
| | Ind + Child(ren) | $1,609.18 | $1,328.43 | $280.75 | **$246.49** | $34.26 |
| | Ind + Partner | $1,917.01 | $1,600.15 | $316.86 | **$278.80** | $38.06 |
| | Family | $1,953.25 | $1,630.35 | $322.90 | **$283.50** | $39.40 |
| **(PPO 90 with copay) Blue Care Elect Preferred 90 Copay** | Individual | $1,190.80 | $634.10 | $556.71 | **$488.77** | $67.93 |
| | Ind + Child(ren) | $2,506.73 | $1,328.43 | $1,178.30 | **$1,034.51** | $143.79 |
| | Ind + Partner | $3,113.76 | $1,600.15 | $1,513.61 | **$1,328.89** | $184.72 |
| | Family | $3,172.21 | $1,630.35 | $1,541.86 | **$1,353.70** | $188.16 |

# Vision Insurance Rates 2022-2023

| | |
|---|---|
| SINGLE coverage | $6.30 |
| FAMILY coverage | $17.20 |

# Dental Insurance Rates for 2022-2023

| | Monthly Premium | College Shared Monthly Cost | Employee Shared Monthly Cost |
|---|---|---|---|
| Dental Blue - Single | $34.91 | $26.18 | $8.73 |
| Dental Blue - Family | $108.22 | $26.18 | $82.04 |
| Dental Blue with Ortho - Single | $40.48 | $26.18 | $14.30 |
| Dental Blue with Ortho - Family | $125.51 | $26.18 | $99.33 |

| 17/18 Monthly | | $ Difference |
|---|---|---|
| 8.79 | | ($0.06) |
| 82.61 | | ($0.57) |

**Preventative - Type 1 Covered at 100%**

* Oral Exams
* X-Rays
* Teeth cleaning
* Flouride treaments
* Sealants -

**Basic Restorative - Type II**

* Fillings
* Simple & Surgical Extractions when rendered in office - not covered when rendered in a surgical day care or hospital setting
* Periodontal Surgery
* Scaling & Root Planing
* Root Canal

**Major Restorative - Type III Covered at 50%**

* Dentures
* Crowns

**Dental Blue** Calendar Year Max of $1000/Person

**Dental Blue with Ortho - Calendar Year Max of $2000/person + 50% orthodontic coverage to a $1,000 lifetime maximum**

Rollover Max Available - Limitations Apply -
Deductible of $50/Person; Max $150/Family per Calendar Year on Type II & III Services

# Prudential

# Supplemental Life Insurance Rates

| Age Bracket | Monthly Cost / $1000 of Coverage |
|---|---|
| < 30 years | 0.000058 |
| 30-34 | 0.000078 |
| 35-39 | 0.000088 |
| 40-44 | 0.000108 |
| 45-49 | 0.000158 |
| 50-54 | 0.000248 |
| 55-59 | 0.000418 |
| 60-64 | 0.000568 |
| 65-69 | 0.001058 |
| 70+ | 0.001708 |

* Find your age bracket

* Multiply the amount of insurance coverage (1-5x your salary) by the monthly cost/$1000

You may elect to retain your current level of Supplemental Life Insurance or you may opt to purchase coverage equal to 1-5 times your salary. There is a maximum of $500,000 in coverage. Amounts that reflect an increase of more than one level of coverage and / or Amounts over $350,000 in coverage will be subject to medical underwriting.

**Level of Coverage**

| | |
|---|---|
| 40% income replacement | MHC pays the premium |
| 50% income replacment | .00178 x monthly salary |
| 60% income replacement | .00186 x monthly salary |
| 66.66% income replacement | .00221 x monthly salary |

Long term disability insurance provides a portion of your income if you become disabled for an extended period of time.
This insurance coverage begins after you have been disabled for a period of 6 months or more.