MOUNT HOLYOKE

Full Time Employee -Benefits Rates 2021-2022

Plan	Level of Coverage	Monthly Premium	College Shared Monthly Cost*	Employee Shared Monthly Cost	For comparison 20/21 Monthly Employee Share	$ Increase
HMO Blue	Individual	$742.28	$556.71	$185.57	**$171.51**	$14.06
	Ind + Child(ren)	$1,597.69	$1,166.31	$431.38	**$398.68**	$32.70
	Ind + Partner	$1,924.49	$1,404.88	$519.61	**$480.23**	$39.38
	Family	$1,960.80	$1,431.39	$529.41	**$489.29**	$40.12
HMO Blue New England (Value HMO) $1,000 deductible	Individual	$651.18	$556.71	$94.47	**$87.31**	$7.16
	Ind + Child(ren)	$1,412.80	$1,166.31	$246.49	**$227.80**	$18.69
	Ind + Partner	$1,683.06	$1,404.88	$278.18	**$257.10**	$21.08
	Family	$1,714.88	$1,431.39	$283.49	**$262.01**	$21.48
(PPO 90 with copay) Blue Care Elect Preferred 90 Copay	Individual	$1,045.48	$556.71	$488.77	**$451.73**	$37.04
	Ind + Child(ren)	$2,200.82	$1,166.31	$1,034.51	**$956.10**	$78.41
	Ind + Partner	$2,733.77	$1,404.88	$1,328.89	**$1,228.18**	$100.71
	Family	$2,785.08	$1,431.39	$1,353.69	**$1,251.10**	$102.59

Vision Insurance Rates 2021-2022

SINGLE coverage	$6.14
FAMILY coverage	$16.78

Dental Insurance Rates for 2021-2022

	Monthly Premium	Shared Monthly Cost	Employee Shared Monthly Cost
Dental Blue - Single	$35.16	$26.37	$8.79
Dental Blue - Family	$108.98	$26.37	$82.61
Dental Blue with Ortho - Single	$40.77	$26.37	$14.40
Dental Blue with Ortho - Family	$126.39	$26.37	$100.02

Monthly EE share		$ Difference
9.23		($0.44)
86.74		($4.13)

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
* Bridge or Denture repair

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	0.058
30-34	0.078
35-39	0.088
40-44	0.108
45-49	0.158
50-54	0.248
55-59	0.418
60-64	0.568
65-69	1.058
70+	1.708

To calculate your monthly premium, multiply the amount of coverage by the factor to the left that corresponds to your age group, then divide by $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 $250,000 in coverage will be subject to medical underwriting.

Level of Coverage

40% income replacement

50% income replacment

60% income replacement

66.66% income replacement

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.