MOUNT HOLYOKE

Full Time Employee -Benefits Rates 2020-2021

Plan	Level of Coverage	Monthly Premium	College Shared Monthly Cost*	Employee Shared Monthly Cost	19/20 Monthly Employee Share (For comparison)	$ Increase
HMO Blue	Individual	$686.03	$514.52	$171.51	**$159.53**	$11.98
	Ind + Child(ren)	$1,476.61	$1,077.93	$398.68	**$357.11**	$41.57
	Ind + Partner	$1,778.64	$1,298.41	$480.23	**$430.15**	$50.08
	Family	$1,812.20	$1,322.91	$489.29	**$438.27**	$51.02
HMO Blue New England (Value HMO) $500 deductible	Individual	$601.83	$514.52	$87.31	**$101.61**	($14.30)
	Ind + Child(ren)	$1,305.73	$1,077.93	$227.80	**$242.43**	($14.63)
	Ind + Partner	$1,555.51	$1,298.41	$257.10	**$275.33**	($18.23)
	Family	$1,584.92	$1,322.91	$262.01	**$280.58**	($18.57)
(PPO 90 with copay) Blue Care Elect Preferred 90 Copay	Individual	$966.25	$514.52	$451.73	**$401.42**	$50.31
	Ind + Child(ren)	$2,034.03	$1,077.93	$956.10	**$836.11**	$119.99
	Ind + Partner	$2,526.59	$1,298.41	$1,228.18	**$1,076.80**	$151.38
	Family	$2,574.01	$1,322.91	$1,251.10	**$1,096.90**	$154.20

Vision Insurance Rates 2020-2021

Coverage	Rate
SINGLE coverage	$5.99
FAMILY coverage	$16.37

Dental Insurance Rates for 2020-2021

	Monthly Premium	College Shared Monthly Cost	Employee Shared Monthly Cost
Dental Blue - Single	$36.91	$27.68	$9.23
Dental Blue - Family	$114.42	$27.68	$86.74
Dental Blue with Ortho - Single	$42.81	$27.68	$15.13
Dental Blue with Ortho - Family	$132.70	$27.68	$105.02

17/18 Monthly	$ Difference
9.23	($0.00)
86.74	($0.00)

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	0.058
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

Long Term Disability Buy Up Options/Rates

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