



MONTHLY COST FOR MEDICAL COVERAGE

	TOTAL PREMIUM		HBSP CONTRIBUTION		EMPLOYEE CONTRIBUTION	
	INDIVIDUAL	FAMILY	INDIVIDUAL	FAMILY	INDIVIDUAL	FAMILY
HMO						
Harvard University Group Health Plan (HUGHP)	\$631.00	\$1,705.00	\$504.80	\$1,364.00	\$126.20	\$341.00
Harvard Pilgrim Health Care (HPHC)	\$646.00	\$1,744.00	\$516.80	\$1,395.20	\$129.20	\$348.80
POS						
HUGHP	\$666.00	\$1,799.00	\$532.80	\$1,439.20	\$133.20	\$359.80
HPHC	\$681.00	\$1,838.00	\$544.80	\$1,470.40	\$132.20	\$367.60
POS Plus						
HUGHP	\$680.00	\$1,835.00	\$516.80	\$1,394.60	\$163.20	\$440.40
HPHC	\$694.00	\$1,874.00	\$527.44	\$1,424.24	\$166.56	\$449.76
HDHP						
HUGHP	\$582.00	\$1,572.00	\$536.00	\$1,452.00	\$46.00	\$120.00
HPHC	\$597.00	\$1,611.00	\$477.60	\$1,288.80	\$119.40	\$322.20



RATES FOR OTHER BENEFITS

DENTAL

Monthly Cost			
	TOTAL PREMIUM	HBSP CONTRIBUTION	EMPLOYEE CONTRIBUTION
INDIVIDUAL	\$50.96	\$31.54	\$19.42
FAMILY	\$144.13	\$89.22	\$54.91

VISION

Monthly Cost	
INDIVIDUAL	\$6.11
FAMILY	\$14.05

LONG TERM DISABILITY (LTD) INSURANCE

FTE Salary Tier	Monthly Cost per \$100 of Salary
Less than \$15,000	\$0.253
\$15,000–\$69,999	\$0.289
\$70,000–\$94,999	\$0.623
\$95,000 and above	\$0.786



SUPPLEMENTAL LIFE INSURANCE

You must be enrolled in Supplemental Life Insurance in order to apply for Spousal/Domestic Partner or Dependent Child(ren) coverage.

Coverage Options		
Who's eligible	Coverage choices	Special requirements for this Open Enrollment period
Existing Supplemental Life Insurance		
Faculty and Staff Members	1x–5x annual salary (rounded to the nearest \$1,000 of coverage), up to \$1.25 million	You can apply for or increase your coverage by completing a full Statement of Health.*
New Dependent Life Insurance		
NEW Spouse / Domestic Partner	Option 1: \$25,000 Option 2: \$50,000 Option 3: \$75,000 Option 4: \$100,000	Enroll for \$25,000 or \$50,000 with no Statement of Health. Apply for \$75,000 or \$100,000 by completing a Statement of Health for your spouse/domestic partner.
NEW Dependent Child(ren) (from birth to age 26)	Option 1: \$5,000 Option 2: \$10,000	No Statement of Health is required.

* MetLife will review your information and evaluate your request for coverage based on your answers to the health questions, MetLife's underwriting rules, and other information you authorize MetLife to review. In certain cases, MetLife may request additional information to evaluate your request for coverage.

Cost per Covered Individual (Employee plus Spouse / Domestic Partner)			
Age	Monthly Cost per \$1,000 of Insurance*	Age	Monthly Cost per \$1,000 of Insurance*
< 25	\$0.022	55–59	\$0.160
25–29	\$0.026	60–64	\$0.204
30–34	\$0.030	65–69	\$0.373
35–39	\$0.036	70–74	\$0.594
40–44	\$0.044	75–79	\$1.091
45–49	\$0.066	80 and over	\$1.562
50–54	\$0.102		

* Based on age of employee, not age of spouse / domestic partner.

Cost of Coverage for Dependent Child(ren)	
Coverage Amount	Monthly Cost of Coverage
\$5,000	\$0.50
\$10,000	\$1.00

One monthly premium covers all of your eligible children.