2022 PLAN DESIGN

	PREMIUM SAVER		BALANCED SAVER		LEGACY PPO	
	Employees Covering Just Themselves	Employees Covering Family Members	Employees Covering Just Themselves	Employees Covering Family Members	Employees Covering Just Themselves	Employees Covering Family Members
Preventive Exams, Screenings & some RXs	FREE	FREE	FREE	FREE	FREE	FREE
Murray State HSA Contribution Opportunity	$400	$800	$400	$800	N/A	N/A
Racer Wellness Incentive Opportunity	Racer Wellness Pledge: Completing Phase 1 results in a incentive of $150. Completion of Phase 2 results in an additional $100 incentive.					
Deductible (excludes copays)	$3,000	$3,000/Individual $6,000/Family	$1,750	$3,500/Family	$600	$600/Individual $1,200/Family
EE Coinsurance (after deductible)	Hospital & Surgery: 10% Other Services: 30%	Hospital & Surgery: 10% Other Services: 30%	Hospital & Surgery: 10% Other Services: 20%	Hospital & Surgery: 10% Other Services: 20%	15% to all services not subject to a copay	15% to all services not subject to a copay
Emergency Room	No copays, Deductible + Coinsurance	No copays, Deductible + Coinsurance	No copays, Deductible + Coinsurance	No copays, Deductible + Coinsurance	$200 copay	$200 copay
Office Visits General / Specialist					$30 / $45	$30 / $45
RX: Generic / BrandF / BrandNF/ Specialty Mail order 2x for copays except specialty					$15 / $35 / $70 / $140 per month	$15 / $35 / $70 / $140 per month
Out-of-pocket limit (including deductible)	$6,000	$6,000/Individual $12,000/Family	$4,250	$4,250/Individual $8,500/Family	$2,500	$2,500/Individual $5,000/Family

ANTHEM MEDICAL MONTHLY PREMIUM

	PREMIUM SAVER		BALANCED SAVER		LEGACY PPO	
	MURRAY STATE	EMPLOYEE	MURRAY STATE	EMPLOYEE	MURRAY STATE	EMPLOYEE
Employee Only	$573.77	$18.27	$590.12	$56.65	$565.24	$147.07
Employee + Child(ren)	$957.14	$50.64	$945.13	$161.17	$901.85	$312.85
Employee + Spouse	$1,040.63	$58.16	$1,027.09	$181.16	$989.29	$350.03
Family	$1,448.99	$126.14	$1,429.75	$309.58	$1,403.60	$563.37

TOBACCO SURCHARGE: Tobacco users will pay a **$55** monthly surcharge in addition to medical premiums.

VOLUNTARY BENEFITS

DENTAL: DELTA DENTAL MONTHLY PREMIUM

CORE		BUY-UP*	
Employee Only	Employee + Dependent(s)	Employee Only	Employee + Dependent(s)
$18.09	**$53.93**	**$27.91**	**$72.99**

*BUY-UP PLAN INCLUDES SOME ORTHODONTIA COVERAGE.

VISION: ANTHEM MONTHLY PREMIUM

Employee Only	Employee + Spouse	Employee + Child(ren)	Family
$7.25	**$13.39**	**$14.21**	**$20.35**

VOYA CRITICAL ILLNESS MONTHLY PREMIUM

NON-TOBACCO AND TOBACCO RATES

	Employee Only		Employee + Child(ren)		Employee + Spouse		Family	
>30	**$7.80**	$10.20	**$10.10**	$12.50	**$11.90**	$15.60	**$14.20**	$17.90
30-39	**$10.20**	$14.60	**$12.50**	$16.90	**$15.75**	$22.60	**$18.05**	$24.90
40-49	**$18.50**	$28.30	**$20.80**	$30.60	**$28.70**	$43.95	**$31.00**	$46.25
50-59	**$31.30**	$49.80	**$33.60**	$52.10	**$48.95**	$78.05	**$51.25**	$80.35
60-64	**$42.50**	$70.20	**$44.80**	$72.50	**$66.20**	$109.50	**$68.50**	$111.80
65-69	**$58.80**	$89.20	**$61.10**	$91.50	**$90.20**	$136.75	**$92.50**	$139.05
70+	**$76.30**	$115.10	**$78.60**	$117.40	**$116.70**	$175.80	**$119.00**	$178.10

VOYA SHORT-TERM DISABILITY

Weekly Benefit Percentage	Max Weekly Benefit Amount	Accident Elimination Period	Sickness Elimination Period	Maximum Benefit Duration
60% of base salary	**$1,000.00**	**1 day**	**8 days**	**13 weeks**

VOYA ACCIDENT MONTHLY PREMIUM

Employee Only	Employee + Spouse	Employee + Child(ren)	Family
$8.52	**$14.42**	**$16.24**	**$22.14**

VOYA HOSPITAL CONFINEMENT INDEMNITY MONTHLY PREMIUM

Employee Only	Employee + Spouse	Employee + Child(ren)	Family
$18.19	**$36.30**	**$27.10**	**$45.21**

MURRAY STATE UNIVERSITY

HUMAN RESOURCES
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