2019 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
MSU HSA Contribution Opportunity	$400	$800	$400	$800	N/A	N/A
Racer Wellness Incentive Opportunity	New Racer Wellness Pledge: Completing Phase 1 results in a reward of $75. Completion of Phase 2 results in an additional $175 reward.					
Deductible (excludes copays)	$3,000	$3,000/Individual $6,000/Family	$1,500	$3,000/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)	$5,500	$5,500/Individual $11,000/Family	$4,000	$4,000/Individual $8,000/Family	$2,000	$2,000/Individual $4,000/Family

ANTHEM MEDICAL MONTHLY PREMIUM

	PREMIUM SAVER		BALANCED SAVER		LEGACY PPO	
	MSU	Employee	MSU	Employee	MSU	Employee
Employee Only	$514.52	$17.35	$528.20	$53.80	$492.56	$139.67
Employee + Child(ren)	$853.93	$48.09	$839.20	$153.06	$776.02	$297.10
Employee + Spouse	$927.12	$55.23	$910.58	$172.04	$850.68	$332.41
Family	$1,282.18	$119.79	$1,258.37	$294.00	$1,199.09	$535.01

ANTHEM VISION MONTHLY PREMIUM

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

DELTA DENTAL MONTHLY PREMIUM

	Core	Buy-up
Employee Only	$18.09	$27.91
Employee + Dependent(s)	$53.93	$72.99

VOLUNTARY BENEFITS

VOYA CRITICAL ILLNESS MONTHLY PREMIUM

	NON-TOBACCO RATES				TOBACCO RATES			
	EE ONLY	EE + CHILD(REN)	EE + SPOUSE	FAMILY	EE ONLY	EE + CHILD(REN)	EE + SPOUSE	FAMILY
Under 30	$7.80	$10.10	$11.90	$14.20	$10.20	$12.50	$15.60	$17.90
30-39	$10.20	$12.50	$15.75	$18.05	$14.60	$16.90	$22.60	$24.90
40-49	$18.50	$20.80	$28.70	$31.00	$28.30	$30.60	$43.95	$46.25
50-59	$31.30	$33.60	$48.95	$51.25	$49.80	$52.10	$78.05	$80.35
60-64	$42.50	$44.80	$66.20	$68.50	$70.20	$72.50	$109.50	$111.80
65-69	$58.80	$61.10	$90.20	$92.50	$89.20	$91.50	$136.75	$139.05
70+	$76.30	$78.60	$116.70	$119.00	$115.10	$117.40	$175.80	$178.10

VOYA SHORT TERM DISABILITY

Weekly Benefit Percentage	60% of base salary
Maximum Weekly Benefit Amount	$1,000.00
Accident Elimination Period	1 Day
Sickness Elimination Period	8 Weeks
Maximum Benefit Duration	13 Weeks

VOYA ACCIDENT MONTHLY PREMIUM

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

VOYA HOSPITAL CONFINEMENT INDEMNITY MONTHLY PREMIUM

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