2024 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 and 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)	$3,200	$3,200/Individual $6,400/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	$719.35	$31.19	$742.86	$80.16	$740.50	$172.97
Employee + Dependent(s)	$1,163.61	$86.57	$1,176.95	$203.70	$1,174.78	$360.13
Employee + Spouse	$1,267.07	$96.49	$1,281.76	$226.77	$1,285.49	$403.94
Employee + Family	$1,745.41	$199.79	$1,768.16	$394.49	$1,794.86	$671.04

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

Murray State employer premiums are preliminary.

Voluntary Benefits

VOYA CRITICAL ILLNESS MONTHLY PREMIUM

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

SHORT-TERM DISABILITY

In the event you become disabled from a non-work-related injury or sickness, disability income benefits can represent a source of income. Short-term disability is also available for maternity leave. You are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits or while receiving sick leave pay. If you are electing short-term disability for the first time, an Evidence of Insurability form (EOI) will be required.

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 days
Maximum Benefit Duration	13 weeks

DENTAL: DELTA DENTAL MONTHLY PREMIUM

CORE		BUY-UP	
EMPLOYEE ONLY	EMPLOYEE + DEPENDENT(S)	EMPLOYEE ONLY	EMPLOYEE + DEPENDENT(S)
$18.72	$55.82	$28.89	$75.54

**Buy-up plan includes some orthodontia coverage.*

VISION: ANTHEM MONTHLY PREMIUM

EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + DEPENDENT(S)	EMPLOYEE + FAMILY
$7.25	$13.39	$14.21	$20.35

LIFE INSURANCE

Employees currently enrolled in the supplemental life plan will have the opportunity to increase coverage by $20,000 up to the guaranteed issue amount of $250,000 without evidence of insurability during open enrollment for the 2024 plan year.

The 2024 plan year rate for supplemental life is $.31 cents per $1,000 — for example, an additional $40,000 supplemental life policy would cost $12.40 per month.

GROUP ACCIDENT

An accident plan pays a cash benefit directly to you if you have a covered injury and need treatment or hospital care. In addition, the plan provides an accidental death benefit. Accident features a reimbursement for completing preventive screens!

VOYA ACCIDENT MONTHLY PREMIUM	
Employee Only	$8.52
Employee + Spouse	$14.42
Employee + Dependent(s)	$16.24
Employee + Family	$22.14

GROUP HOSPITAL CONFINEMENT INDEMNITY

A Hospital Indemnity plan pays a cash benefit directly to you in the event you or a covered family member are admitted to the hospital. The cash benefit you receive can be used to assist in paying expenses associated with a hospital stay.

VOYA HOSPITAL CONFINEMENT INDEMNITY MONTHLY PREMIUM	
Employee Only	$18.19
Employee + Spouse	$36.30
Employee + Dependent(s)	$27.10
Employee + Family	$45.21