

Medical Benefits Costs

There are three plan designs from which to choose when selecting your medical insurance option: Blue Access High, Blue Access Standard and Blue Access Economy. All three plans utilize the same PPO network. The differences in the plans are in the deductibles, copays, coinsurance, visit limitations for certain services and out-of-pocket maximums.

Once a medical plan is selected, it remains in effect for the full plan period (July 1 – December 31, 2008). Changes in enrollment are only permitted during the plan period for qualified events such as marriage, divorce, death, legal separation, birth or adoption of a child. Otherwise, changes are made only during open enrollment and are effective January 1st of the same calendar year.

Blue Access High-Option PPO	Total Monthly Premium	University Monthly Contribution	Employee Monthly Premium	Faculty (20 Pays)	Semi-Monthly (24 Pays)	Bi-Weekly (26 Pays)
Employee Only	\$447.93	\$401.72	\$46.21	\$27.73	\$23.11	\$21.33
Employee + Spouse	\$754.30	\$457.72	\$296.58	\$177.95	\$148.29	\$136.88
Employee + Child(ren)	\$715.76	\$450.68	\$265.08	\$159.05	\$132.54	\$122.35
Employee + Family	\$1,158.50	\$561.06	\$597.44	\$358.46	\$298.72	\$275.74
Two (2) EKU Employees + Family		Up to \$803.44	\$294.69	\$176.81	\$147.35	\$136.01

Blue Access Standard Option PPO	Total Monthly Premium	University Monthly Contribution	Employee Monthly Premium	Faculty (20 Pays)	Semi-Monthly (24 Pays)	Bi-Weekly (26 Pays)
Employee Only	\$398.02	\$398.02	\$0.00	\$0.00	\$0.00	\$0.00
Employee + Spouse	\$605.99	\$398.02	\$207.97	\$124.78	\$103.99	\$95.99
Employee + Child(ren)	\$578.10	\$398.02	\$180.08	\$108.05	\$90.04	\$83.11
Employee + Family	\$923.27	\$507.85	\$415.42	\$249.25	\$207.71	\$191.73
Two (2) EKU Employees + Family		Up to \$796.04	\$180.08	\$108.05	\$90.04	\$83.11

Blue Access Economy Option PPO	Total Monthly Premium	University Monthly Contribution	Employee Monthly Premium	Faculty (20 Pays)	Semi-Monthly (24 Pays)	Bi-Weekly (26 Pays)
Employee Only	N/A	N/A	N/A	N/A	N/A	N/A
Employee + Spouse	\$451.62	\$398.02	\$53.60	\$32.16	\$26.80	\$24.74
Employee + Child(ren)	\$433.53	\$398.02	\$35.51	\$21.31	\$17.76	\$16.39
Employee + Family	\$579.44	\$467.32	\$112.12	\$67.27	\$56.06	\$51.75
Two (2) EKU Employees + Family		Up to \$796.04	\$0	\$0	\$0	\$0

*Two (2) employees in the same plan with no children receive up to 100% of the respective plan's cost.

Blue Access High Option

		In Network	Out-of-Network
Annual Deductible (Single/Family)	Deductibles apply to expenses with a % copay	\$250/\$500	\$500/\$1,000
Out-of-Pocket Maximum (Single/Family)	Deductibles are included	\$1,250/\$2,500	\$2,500/\$5,000
Physician Office Services	If only charge from a physician office visit is for allergy injections, allergy serum, diagnostic services or Other Therapy services, any copay is waived. % copays are not.	\$15 copay	Deductible, then 30%
Preventive Care	Medical history, mammography, pelvic exams, and pap testing, PSA tests, immunizations, annual diabetic eye exam	\$15 copay	Deductible, then 30%
Physical Medicine Therapies (when rendered as Physician Office or Outpatient Service) Combined Network & Non-network limits apply	Physical/Occupational Therapy- 40 visit limit Speech Therapy- 40 visit limit Chiropractic- 20 visit limit	\$15 copay	Deductible, then 30%
Inpatient Services	Unlimited days, except for 60 days per benefit period limit combined network/out-of-network for inpatient physical medicine/rehabilitation	Deductible, then 5%	Deductible, then 30%
Outpatient Services	Outpatient Surgery Hospital/Alternative Care Facility Other Outpatient Services Hospital/Alternative Care Facility	Deductible, then 5%	Deductible, then 30%
Mental Health (MH)/Substance Abuse (SA) (Administered through Behavioral Medicine Network)	Inpatient MH/SA- 20 days combined per benefit period maximum. Inpatient/Outpatient SA rehab programs limited to 2 per lifetime.	Deductible, then 5%	MH- not covered SA- Deductible, then 30% (\$550 combined Max)
	Outpatient or physician's office MH/SA- 30 visits combined per benefit period (calendar year) maximum	\$15 copay	Deductible, then 30% (MH 10 visits per benefit period/SA \$550 combined Max)
Prescription (Generic / Brand / Non- Formulary) (Administered through Express Scripts)	Network Retail Pharmacies 30 day supply	\$7/\$25/\$40	Deductible, then 50%
	Mail Order Service 90-day supply	\$14/\$50/\$80	N/A
Emergency and Urgent Care	Emergency care in ER covers all services; ER copay waived if admitted and inpatient copay would apply.	\$75 copay per visit	\$75 copay per visit
	Urgent Care (In Urgent Care Center) Ambulance Services (Medically Necessary Ground)	\$35 copay per visit Covered in Full	\$35 copay per visit Covered in Full
Home Care Services	Unlimited in-network visits; 30 visits out-of-network limit	Deductible, then 5%	Deductible, then 30%
Other Services	Hospice Services Maternity Services (Facility/Ancillary/Professional)	Covered in Full Deductible, then 5%	Covered in Full Deductible, then 30%
Lifetime Maximum (including kidney and cornea transplants)	Combined Network and Non-network	\$1,000,000	
Human Organ and Tissue Transplants (Except kidney and cornea transplants)	Heart, heart/lung, liver, lung, pancreas only when simultaneous with kidney or following kidney transplant. \$1,000,000 separate Lifetime Maximum	See Summary Plan Description	See Summary Plan Description
Miscellaneous	Medical Supplies, Equipment and Appliances	Deductible, then 20%	Deductible, then 40%

NOTE: All services subject to deductible and copays accumulate towards the Out-of-Pocket maximum. This excludes copays for prescription drugs. Deductibles, Out-of-Pocket maximums and therapy visits run on a calendar year.

Blue Access Standard Option

		In Network	Out-of-Network
Annual Deductible (Single/Family)	Deductibles apply to expenses with a % copay	\$500/\$1,000	\$1,000/\$2,000
Out-of-Pocket Maximum (Single/Family)	Deductibles are included	\$2,000/\$4,000	\$4,000/\$8,000
Physician Office Services	If only charge from a physician office visit is for allergy injections, allergy serum, diagnostic services or Other Therapy services, any copay is waived. % copays are not.	\$15 copay	Deductible, then 40%
Preventive Care	Medical history, mammography, pelvic exams, and pap testing, PSA tests, immunizations, annual diabetic eye exam	\$15 copay	Deductible, then 40%
Physical Medicine Therapies (when rendered as Physician Office or Outpatient Service) Combined Network & Non-network limits apply	Physical/Occupational Therapy- 30 visit limit Speech Therapy- 30 visit limit Chiropractic- 15 visit limit	\$15 copay	Deductible, then 40%
Inpatient Services	Unlimited days except for 60 days per benefit period limit combined network/out-of-network for inpatient physical medicine/rehabilitation	Deductible, then 20%	Deductible, then 40%
Outpatient Services	Outpatient Surgery Hospital/Alternative Care Facility Other Outpatient Services Hospital/Alternative Care Facility	Deductible, then 20%	Deductible, then 40%
Mental Health (MH)/Substance Abuse (SA) (Administered through Behavioral Medicine Network)	Inpatient MH/SA- 20 days combined per benefit period maximum. Inpatient/Outpatient SA-rehab programs limited to 2 per lifetime.	Deductible, then 20%	MH- not covered SA- Deductible, then 40% (\$550 combined Max)
	Outpatient or physician's office MH/SA- 30 visits combined per benefit period (calendar year) maximum	\$15 copay	Deductible, then 40% (MH 10 visits per benefit period/SA \$550 combined Max)
Prescription (Generic / Brand / Non- Formulary) (Administered through Express Scripts)	Network Retail Pharmacies 30 day supply	\$7/\$25/\$40	Deductible, then 50%
	Mail Order Service 90-day supply	\$14/\$50/\$80	N/A
Emergency and Urgent Care	Emergency care in ER covers all services; ER copay waived if admitted and inpatient copay would apply.	\$75 copay per visit	\$75 copay per visit
	Urgent Care (In Urgent Care Center)	\$35 copay per visit	\$35 copay per visit
	Ambulance Services (Medically Necessary Ground)	Covered in Full	Covered in Full
Home Care Services	Unlimited in-network visits; 30 visits out-of-network limit	Deductible, then 20%	Deductible, then 40%
Other Services	Hospice Services Maternity Services (Facility/Ancillary/Professional)	Covered in Full Deductible, then 20%	Covered in Full Deductible, then 40%
Lifetime Maximum (including kidney and cornea transplants)	Combined Network and Non-network	\$1,000,000	
Human Organ and Tissue Transplants (Except kidney and cornea transplants)	Heart, heart/lung, liver, lung, pancreas only when simultaneous with kidney or following kidney transplant. \$1,000,000 separate Lifetime Maximum	See Summary Plan Description	See Summary Plan Description
Miscellaneous	Medical Supplies, Equipment and Appliances	Deductible, then 20%	Deductible, then 40%

Note: All services subject to deductible and copays accumulate towards the Out-of-Pocket maximum. This excludes copays for prescription drugs. Deductibles, Out-of-Pocket maximums and therapy visits run on a calendar year.

Blue Access Economy Option

		In Network	Out-of-Network
Annual Deductible (Single/Family)	Deductibles apply to expenses with a % copay	\$2,500/\$5,000	\$5,000/\$10,000
Out-of-Pocket Maximum (Single/Family)	Deductibles are included	\$4,000/\$8,000	\$8,000/\$16,000
Physician Office Services	If only charge from a physician office visit is for allergy injections, allergy serum, diagnostic services or Other Therapy services, any copay is waived. % copays are not.	\$40 copay	Deductible, then 50%
Preventive Care	Medical history, mammography, pelvic exams, and pap testing, PSA tests, immunizations, annual diabetic eye exam	\$40 copay	Deductible, then 50%
Physical Medicine Therapies (when rendered as Physician Office or Outpatient Service) Combined Network & Non-network limits apply	Physical/Occupational Therapy- 20 visit limit Speech Therapy- 20 visit limit Chiropractic- 12 visit limit	\$40 copay	Deductible, then 50%
Inpatient Services	Unlimited days except for 60 days per benefit period limit combined network/out-of-network for inpatient physical medicine/rehabilitation	Deductible, then 30%	Deductible, then 50%
Outpatient Services	Outpatient Surgery Hospital/Alternative Care Facility Other Outpatient Services Hospital/Alternative Care Facility	Deductible, then 30%	Deductible, then 50%
Mental Health (MH)/Substance Abuse (SA) (Administered through Behavioral Medicine Network)	Inpatient MH/SA- 20 days combined per benefit period maximum. Inpatient/Outpatient SA rehab programs limited to 2 per lifetime.	Deductible, then 30%	MH- not covered SA- Deductible, then 50% (\$550 combined Max)
	Outpatient or physician's office MH/SA- 30 visits combined per benefit period (calendar year) maximum	\$40 copay	Deductible, then 50% (MH 10 visits per benefit period/SA \$550 combined Max)
Prescription (Generic / Brand / Non- Formulary) (Administered through Express Scripts)	Network Retail Pharmacies 30 day supply	Deductible (Per Member): \$200, then 50% (min. \$20 / max. \$70)	Deductible (Per Member): \$200, then 50% (min. \$50)
	Mail Order Service 90-day supply	\$50 Generic per order \$50 Brand per order	N/A N/A
Emergency and Urgent Care	Emergency care in ER covers all services; ER copay waived if admitted and inpatient copay would apply.	Deductible, then 30%	Deductible, then 30%
	Urgent Care (In Urgent Care Center) Ambulance Services (Medically Necessary Ground)	Deductible, then 30% Covered in Full	Deductible, then 30% Covered in Full
Home Care Services	Unlimited in-network visits; 30 visits out-of-network limit	Deductible, then 30%	Deductible, then 50%
Other Services	Hospice Services Maternity Services (Facility/Ancillary/Professional)	Covered in Full Deductible, then 30%	Covered in Full Deductible, then 50%
Lifetime Maximum (including kidney and cornea transplants)	Combined Network and Non-network	\$1,000,000	
Human Organ and Tissue Transplants (Except kidney and cornea transplants)	Heart, heart/lung, liver, lung, pancreas only when simultaneous with kidney or following kidney transplant. \$1,000,000 separate Lifetime Maximum	See Summary Plan Description	See Summary Plan Description
Miscellaneous	Medical Supplies, Equipment and Appliances	Deductible, then 30%	Deductible, then 50%

NOTE: All services subject to deductible and copays accumulate towards the Out-of-Pocket maximum. This excludes copays for prescription drugs. Deductibles, Out-of-Pocket maximums and therapy visits run on a calendar year.

New for 2008



EXPRESS SCRIPTS®

Prescription Drug Coverage Update

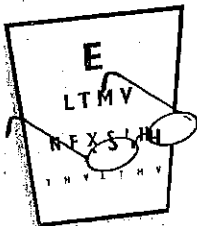
- Generic Drug copays decreased from \$15 to \$7 for the High and Standard health plans.

Step Therapy Program

Effective July 1, 2008, the University is implementing a "Step Therapy" program through Express Scripts. Highlights of this program are listed below.

- Encourages employees to utilize medications that are lower in cost.
- There will be \$0 copay for the first 3 months to members switching from brand name to generic prescription drugs.

See page 6 for more details on the Step Therapy program.



Anthem Blue View Vision Update

- Frame allowance increased from \$120 to \$130 (covered once every 24 months).
- Contact Lens allowance increased from \$105 to \$130 (covered once every 12 months).
- No premium increase!

See page 16 for more details on the vision plan.

The Hartford offers Spouse and Dependent Life Insurance

- If you elect the additional life insurance for yourself, you may elect additional life coverage for your spouse. Your election may be made in increments of \$5,000 to a maximum of \$225,000 but may not exceed 50% of your approved election. New Hires: If you elect an amount that exceeds the guaranteed issue amount of \$25,000, your spouse will need to provide evidence of good health that is satisfactory to The Hartford before the excess can become effective.
- If you elect the additional life insurance for yourself, you may elect additional life coverage for your dependent child(ren) between the ages of 2 weeks and 19 years (25 years if a full time student) in the amount of \$10,000.

Refer to The Hartford Enrollment packet for rates and additional information on life insurance benefits.