

Additional Medical Options for Louisville FOP - 2008

Benefit/Feature	Humana FOP		Anthem FOP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Choice of doctors and hospitals	Use any doctor but better coverage in-network; must use network hospitals except in emergency		Use any doctor but better coverage in-network; must use network hospitals except in emergency	
Need to select a primary care physician?	No	No	No	No
Annual deductible	\$0 \$0	\$50/person \$150/family	\$0 \$0	\$50/person \$150/family
Annual out-of-pocket expense limit (including deductible)	\$400/person \$1,200/family	\$400/person \$1,200/family	\$400/person \$1,200/family	\$400/person \$1,200/family
Doctor's office visits	\$20 copay/visit	80% ¹	\$20 copay/visit	80% ¹
Inpatient/ER physician care	Covered in full	80% ¹	Covered in full	80% ¹
Diagnostic tests	Covered under office visit copay	80% ¹	Covered under office visit copay	80% ¹
In doctor's office	Covered under office visit copay	80% ¹	Covered under office visit copay	80% ¹
Other laboratory	Covered under office visit copay	80% ¹	Covered under office visit copay	80% ¹
Inpatient hospital	Covered in full	Not covered except in emergencies	Covered in full	Not covered except in emergencies
Outpatient hospital	Covered in full	Not covered except in emergencies	Covered in full	Not covered except in emergencies
Emergency room	\$50 copay/visit	\$50 copay/visit	\$50 copay/visit	\$50 copay/visit
Urgent care centers	\$35 copay/visit	\$35 copay/visit	\$35 copay/visit	\$35 copay/visit
Prescription drug coverage				
Retail Pharmacies (30-day supply)	\$3 copay generic \$7 copay preferred brands \$15 non-formulary Not covered	Not covered	\$3 copay generic \$7 copay preferred brands \$15 non-formulary Not covered	Not covered
Mail order (90-day supply)	Not covered	Not covered	Not covered	Not covered
Allergy services				
Testing	\$10 office visit copay	80% ¹	\$10 office visit copay	80% ¹
Serum	Covered in full	80% ¹	Covered in full	80% ¹
Injections	Covered in full	80% ¹	Covered in full	80% ¹
Ambulance	Covered in full	Covered in full	Covered in full	Covered in full
Skilled nursing facility	Covered in full	Not covered	Covered in full	Not covered
Mental health/substance abuse				
Inpatient	Covered in full	Not covered except in emergencies	Covered in full ²	Substance abuse only ²
Outpatient	\$10 copay/visit	Not covered	\$10 copay/visit	80% ¹
Home health care	Covered in full	80% ¹ (limit 30 visits/year)	Covered in full	80% ¹ (limit 30 visits/year)
Well child care (0-18 years old)	\$20 copay/visit	80% ¹	\$20 copay/visit	80% ¹
Well adult care	\$20 copay/visit	80% ¹	\$20 copay/visit	80% ¹
Vision (eye exams)	\$10 copay/visit (every year)	80% ¹	\$10 copay/visit (every year)	80% ¹
Therapy services (up to 20 visits per year)	\$10 copay/visit	80% ^{1,3}	\$10 copay/visit	80% ^{1,3}
Chiropractic care (must be reviewed for medical necessity)	\$10 copay/visit (limit 12 visits/year)	80% ^{1,3}	\$10 copay/visit (limit 12 visits/year)	80% ^{1,3}
Lifetime maximum benefit	\$1 million	\$1 million	\$1 million	\$1 million

YOUR 2008 MONTHLY MEDICAL COSTS		
Level of Coverage	FOP Plan	Non-FOP*
Employee only	\$20	\$20
Employee + spouse	\$40	\$20
Employee + child/children	\$30	\$20
Family	\$50	\$20

* Please see pages 9 - 11 of your enrollment guide for details about these plans.



¹ After annual deductible ² Must be authorized by Magellan Behavioral Health. Combined limit of \$550/year for inpatient substance abuse (in-network and out-of-network). ³ Combined limit of 20 visits/year (in-network and out-of-network)