Active Employees and Non-Medicare Retirees (RETIREMENT DATE ON or AFTER March 1, 2015) Benefits Comparison Benefits effective January 1, 2024 - December 31, 2024				
	Pelican HRA1000		**Pelican HSA775**	
Network	Blue Cross and Blue Shield of Louisiana Preferred Care Providers & Blue Cross National Providers		Blue Cross and Blue Shield of Louisiana Preferred Care Providers & Blue Cross National Providers	
Eligible OGB Members	Active Employees & Non-Medicare Retirees (retirement date on or AFTER 3-1-2015)		Active Employees	
	Network	**Out-of-Network**	**Network**	**Out-of-Network**
	You Pay		**You Pay**	
Deductible				
You	$2,000	$4,000	$2,000	$4,000
You + 1 (Spouse or child)	$4,000	$8,000	$4,000	$8,000
You + Children	$4,000	$8,000	$4,000	$8,000
You + Family	$4,000	$8,000	$4,000	$8,000
	HRA dollars will reduce this amount		HSA dollars will reduce this amount	
Out-of-Pocket Maximum				
You	$5,000	$10,000	$5,000	$10,000
You + 1 (Spouse or child)	$10,000	$20,000	$10,000	$20,000
You + Children	$10,000	$20,000	$10,000	$20,000
You + Family	$10,000	$20,000	$10,000	$20,000
State Funding	**The Plan Pays**		**The Plan Pays**	
You	$1,000		$775*	
You + 1 (Spouse or child)	$2,000		$775*	
You + Children	$2,000		$775*	
You + Family	$2,000		$775*	
	Funding not applicable to Pharmacy Expenses.		*$200, plus up to $575 more dollar for dollar match of employee contributions[5]	
Physicians' Services	**The Plan Pays**		**The Plan Pays**	
Primary Care Physician or Specialist Office - Treatment of illness or injury	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible

Active Employees and Non-Medicare Retirees
(RETIREMENT DATE ON or AFTER March 1, 2015)
Benefits Comparison
Benefits effective January 1, 2024 - December 31, 2024

Magnolia Local Plus		Magnolia Open Access		Magnolia Local	
Blue Cross and Blue Shield of Louisiana Preferred Care Provider & Blue Cross National Providers		Blue Cross and Blue Shield of Louisiana Preferred Care Provider & Blue Cross National Providers		Blue Cross and Blue Shield of Louisiana Community Blue & Blue Connect	
Active Employees & Non-Medicare Retirees (retirement date on or AFTER 3-1-2015)		Active Employees & Non-Medicare Retirees (retirement date on or AFTER 3-1-2015)		Active Employees & Non-Medicare Retirees (retirement date on or AFTER 3-1-2015)	
Network	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**
You Pay		**You Pay**		**You Pay**	
Deductible					
$400	No Coverage	$900	$900	$400	No Coverage
$800	No Coverage	$1,800	$1,800	$800	No Coverage
$1,200	No Coverage	$2,700	$2,700	$1,200	No Coverage
$1,200	No Coverage	$2,700	$2,700	$1,200	No Coverage
Out-of-Pocket Maximum					
$3,500	No Coverage	$3,500	$4,700	$2,500	No Coverage
$6,000	No Coverage	$6,000	$8,500	$3,000	No Coverage
$8,500	No Coverage	$8,500	$12,250	$7,500	No Coverage
$8,500	No Coverage	$8,500	$12,250	$7,500	No Coverage
The Plan Pays		**The Plan Pays**		**The Plan Pays**	
Not Available		Not Available		Not Available	
The Plan Pays		**The Plan Pays**		**The Plan Pays**	
100% coverage after a $25 PCP or $50 SPC copay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a $25 PCP or $50 SPC copay per visit	No Coverage

Active Employees and Non-Medicare Retirees
(RETIREMENT DATE ON or AFTER March 1, 2015)
Benefits Comparison
Benefits effective January 1, 2024 - December 31, 2024

	Pelican HRA1000		Pelican HSA775	
	Network	Out-of-Network	Network	Out-of-Network
Physicians' Services	**The Plan Pays**		**The Plan Pays**	
Maternity Care (prenatal, delivery and postpartum)	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Physician Services Furnished in a Hospital Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist.	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Preventative Care Primary Care Physician or Specialist Office or Clinic For a complete list of benefits, refer to the Preventive and Wellness/ Routine Care in the Benefit Plan	100% coverage; **not** subject to deductible	100% of fee schedule amount. Plan participant pays the difference between the billed amount and the fee schedule amount; **Not** subject to deductible	100% coverage; **not** subject to deductible	100% of fee schedule amount. Plan participant pays the difference between the billed amount and the fee schedule amount; **Not** subject to deductible
Physician Services for Emergency Room Care	80% coverage; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible
Allergy Shots and Serum Copay per visit is applicable only to office visit	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/ Services When billed as office visits	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/ Services When billed as outpatient surgery at a facility	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Services	**The Plan Pays**		**The Plan Pays**	
Inpatient Services Inpatient care, delivery and inpatient short-term acute rehabilitation services	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible

Active Employees and Non-Medicare Retirees
(RETIREMENT DATE ON or AFTER March 1, 2015)
Benefits Comparison
Benefits effective January 1, 2024 - December 31, 2024

Magnolia Local Plus		Magnolia Open Access		Magnolia Local	
Network	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**
The Plan Pays		**The Plan Pays**		**The Plan Pays**	
100% coverage; after a $90 copay per pregnancy	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a $90 copay per pregnancy	No Coverage
100% coverage; subject to deductible	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; subject to deductible	No Coverage
100% coverage; **not** subject to deductible	No Coverage	100% coverage; **not** subject to deductible	70% coverage; subject to deductible	100% coverage; **not** subject to deductible	No Coverage
100% coverage; subject to deductible	100% coverage; subject to deductible	90% coverage; subject to deductible	90% coverage; subject to deductible	100% coverage; subject to deductible	100% coverage; subject to deductible
100% coverage after a $25 PCP or $50 SPC per office visit copay per visit; shots and serum 100% after deductible	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a $25 PCP or $50 SPC per office visit copay per visit; shots and serum 100% after deductible	No Coverage
100% coverage; after a $25 PCP or $50 SPC per office visit copay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a $25 PCP or $50 SPC per office visit copay per visit	No Coverage
100% coverage; subject to deductible	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; subject to deductible	No Coverage
The Plan Pays		**The Plan Pays**		**The Plan Pays**	
100% coverage; after a $100 copay per day max $300 per admission	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible + $50 copay per day (days 1 - 50)	100% coverage; after a $100 copay per day max $300 per admission	No Coverage

Active Employees and Non-Medicare Retirees
(RETIREMENT DATE ON or AFTER March 1, 2015)
Benefits Comparison
Benefits effective January 1, 2024 - December 31, 2024

	Pelican HRA1000		Pelican HSA775	
	Network	Out-of-Network	Network	Out-of-Network
Hospital Services	The Plan Pays		The Plan Pays	
Outpatient Surgery/Services Hospital / Facility	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Emergency Room - Hospital (Facility) Treatment of an emergency medical condition or injury	80% coverage; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible
Behavioral Health	The Plan Pays		The Plan Pays	
Mental Health and Substance Abuse Inpatient Facility	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Mental Health and Substance Abuse Outpatient Visits - Professional	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Other Coverage	The Plan Pays		The Plan Pays	
Outpatient Acute Short-Term Rehabilitation Services Physical Therapy, Speech Therapy, Occupational Therapy, Other short term rehabilitative services	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Chiropractic Care	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Hearing Aid Not covered for individuals age eighteen (18) and older	80% coverage; subject to deductible	No Coverage	80% coverage; subject to deductible	No Coverage
Vision Exam (routine) and Eye Wear	No Coverage	No Coverage	No Coverage	No Coverage
Comprehensive Dental	No Coverage	No Coverage	No Coverage	No Coverage
Urgent Care Center	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Home Health Care Services	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible

Active Employees and Non-Medicare Retirees (RETIREMENT DATE ON or AFTER March 1, 2015) Benefits Comparison Benefits effective January 1, 2024 - December 31, 2024					
Magnolia Local Plus		**Magnolia Open Access**		**Magnolia Local**	
Network	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**
The Plan Pays		**The Plan Pays**		**The Plan Pays**	
100% coverage; after a $100 facility copay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a $100 facility copay per visit	No Coverage
100% coverage after $200 copay per visit; waived if admitted	100% coverage after $200 copay per visit; waived if admitted	90% coverage; subject to deductible; $200 copay per visit; waived if admitted	90% coverage; subject to deductible; $200 copay per visit; waived if admitted	100% coverage after $200 copay per visit; waived if admitted	100% coverage after $200 copay per visit; waived if admitted
The Plan Pays		**The Plan Pays**		**The Plan Pays**	
100% coverage; after a $100 copay per day max $300 per admission	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible + $50 copay per day (days 1-5)	100% coverage; after a $100 copay per day max $300 per admission	No Coverage
100% coverage; after a $25 copay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a $25 copay per visit	No Coverage
The Plan Pays		**The Plan Pays**		**The Plan Pays**	
100% coverage; after a $25 copay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a $25 copay per visit	No Coverage
100% coverage; after a $25 copay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a $25 copay per visit	No Coverage
80% coverage; subject to deductible	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	80% coverage; subject to deductible	No Coverage
No Coverage	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage
No Coverage	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage
100% coverage after a $50 copay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a $50 copay per visit	No Coverage
100% coverage subject to deductible	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage subject to deductible	No Coverage

Active Employees and Non-Medicare Retirees
(RETIREMENT DATE ON or AFTER March 1, 2015)
Benefits Comparison
Benefits effective January 1, 2024 - December 31, 2024

	Pelican HRA1000		Pelican HSA775	
	Network	Out-of-Network	Network	Out-of-Network
Other Coverage	**The Plan Pays**		**The Plan Pays**	
Skilled Nursing Facility Services	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Hospice Care	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Durable Medical Equipment (DME) - Rental or Purchase	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Transplant Services	80% coverage; subject to deductible	No Coverage	80% coverage; subject to deductible	No Coverage
Pharmacy	**You Pay**		**You Pay**	
Tier 1 - Generic	50% up to $30 [1]		$10; subject to deductible [1]	
Tier 2 - Preferred	50% up to $55 [1,2]		$25; subject to deductible [1]	
Tier 3 - Non-Preferred	65% up to $80 [1,2]		$50; subject to deductible [1]	
Tier 4 - Specialty	50% up to $80 [1,2]		$50; subject to deductible [1]	
90 day supply for maintenance drugs from mail order OR at participating 90-day retail network pharmacies	2.5 times the cost of applicable maximum copay		Applicable copay; Maintenance drugs not subject to deductible**	
After the out-of-pocket threshold amount of $1,500 is met by you and/or your covered dependent(s):				
Tier 1 - Generic	$0 copay [1]		N/A	
Tier 2 - Preferred	$20 copay [1,2]		N/A	
Tier 3 - Non-Preferred	$40 copay [1,2]		N/A	
Tier 4 - Specialty	$40 copay [1,2]		N/A	

NOTE: Prior Authorizations and Visit Limits may apply to some benefits - refer to your Plan Document for details.

This comparison chart is a summary of plan features and is presented for general information only. It is not a guarantee of coverage.
** For a complete list of maintenance medications visit: https://www.bcbsla.com/ogb/pelican-hsa-775-active-employees

Active Employees and Non-Medicare Retirees
(RETIREMENT DATE ON or AFTER March 1, 2015)
Benefits Comparison
Benefits effective January 1, 2024 - December 31, 2024

Magnolia Local Plus		Magnolia Open Access		Magnolia Local	
Network	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**
The Plan Pays		**The Plan Pays**		**The Plan Pays**	
100% coverage; after a $100 copay per day max $300 per admission	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a $100 copay per day max $300 per admission	No Coverage
100% coverage; subject to deductible	No Coverage	80% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; subject to deductible	No Coverage
80% coverage of the first $5,000 allowable; subject to deductible; 100% in excess of $5,000 per plan year	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	80% coverage of the first $5,000 allowable; subject to deductible 100% in excess of $5,000 per plan year	No Coverage
100% coverage; not subject to deductible	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; subject to deductible	No Coverage
You Pay		**You Pay**		**You Pay**	
50% up to $30 [1]		50% up to $30 [1]		50% up to $30 [1]	
50% up to $55 [1,2]		50% up to $55 [1,2]		50% up to $55 [1,2]	
65% up to $80 [1,2]		65% up to $80 [1,2]		65% up to $80 [1,2]	
50% up to $80 [1,2]		50% up to $80 [1,2]		50% up to $80 [1,2]	
2.5 the cost of applicable maximum copay		2.5 the cost of applicable maximum copay		2.5 times the cost of applicable maximum copay	
After the out-of-pocket threshold amount of $1,500 is met by you and/or your covered dependent(s)[4]:					
$0 copay [1]				$0 copay [1]	
$20 copay [1,2]				$20 copay [1,2]	
$40 copay [1,2]				$40 copay [1,2]	
$40 copay [1,2]				$40 copay [1,2]	

[1] Prescription drug benefit - 31-day fill
[2] Member who chooses brand-name drug for which approved generic version is available pays cost difference between brand-name drug & generic drug, plus copay for brand-name drug; cost difference does not apply to $1,500 out-of-pocket threshold (if applicable).
[3] Prescription drug benefit - 30-day fill