

**Retirees with Medicare (RETIREMENT DATE BEFORE March 1, 2015)**

**Benefits Comparison**

**Benefits effective January 1, 2016 - December 31, 2016**

|   | <b>Pelican HRA 1000</b>  |                                     | <b>Magnolia Local Plus</b>   |                    |
|---|--|-------------------------------------|--|--------------------|
| 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  | Medicare Retirees<br>(retirement date BEFORE 3/1/2015)   |                                     | Medicare Retirees<br>(retirement date BEFORE 3/1/2015)   |                    |
|   | <b>Network</b>   | <b>Non-Network</b>                  | <b>Network</b>   | <b>Non-Network</b> |
|   | <b>You Pay</b>   |                                     | <b>You Pay</b>   |                    |
|   | <b>Deductible</b>  |                                     |  |                    |
| You   | \$2,000  | \$4,000                             | \$0  | No Coverage        |
| You + 1 (Spouse or child)   | \$4,000  | \$8,000                             | \$0  |                    |
| You + Children  | \$4,000  | \$8,000                             | \$0  |                    |
| You + Family  | \$4,000  | \$8,000                             | \$0  |                    |
|   | HRA dollars will reduce this amount  |                                     |  |                    |
|   | <b>Out of Pocket Maximum</b>   |                                     |  |                    |
| You   | \$5,000  | \$10,000                            | \$1,000  | No Coverage        |
| You + 1 (Spouse or child)   | \$10,000   | \$20,000                            | \$2,000  |                    |
| You + Children  | \$10,000   | \$20,000                            | \$3,000  |                    |
| You + Family  | \$10,000   | \$20,000                            | \$3,000  |                    |
| <b>State Funding</b>  | <b>The Plan Pays</b>   |                                     | <b>The Plan Pays</b>   |                    |
| You   | \$1,000  |                                     | Not Available  |                    |
| You + 1 (Spouse or child)   | \$2,000  |                                     |  |                    |
| You + Children  | \$2,000  |                                     |  |                    |
| You + Family  | \$2,000  |                                     |  |                    |
|   | Funding not applicable to Pharmacy Expenses.   |                                     |  |                    |
| <b>Physicians' Services</b>   | <b>The Plan Pays</b>   |                                     | <b>The Plan Pays</b>   |                    |
| <b>Primary Care Physician or Specialist Office - Treatment of illness or injury</b> | 80% coverage; subject to deductible  | 60% coverage; subject to deductible | 100% coverage after a \$25 PCP or \$50 SPC co-payment per visit                                  | No Coverage        |

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| Magnolia Open Access  |                                     | Magnolia Local  |             | Vantage Medical Home  |  |
|---|-------------------------------------|---|-------------|---|--|
| 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 |             | Tier I (Affinity Health Network "AHN" and standard), Tier II, and Out-of-Network  |  |
| Medicare Retirees (retirement date BEFORE 3/1/2015)   |                                     | Medicare Retirees (retirement date BEFORE 3/1/2015)                   |             | Medicare Retirees   |  |
| Network   | Non-Network                         | Network   | Non-Network | Tier I Network  | Non-Network  |
| You Pay   |                                     | You Pay   |             | You Pay   |  |
| \$300   |                                     | \$0   | No Coverage | \$0   | \$1,500  |
| \$600   |                                     | \$0   |             | \$0   | \$3,000  |
| \$900   |                                     | \$0   |             | \$0   | \$4,500  |
| \$900   |                                     | \$0   |             | \$0   | \$4,500  |
| Out of Pocket Maximum   |                                     |   |             |   |  |
| \$2,300 individual; plus \$2,300 per additional person up to 2; plus \$2,000 per additional person up to 2 additional people; \$12,700 for a family of 5+ |                                     | \$1,000   | No Coverage | \$1,000   | No Maximum   |
|   |                                     | \$2,000   |             | \$2,000   | No Maximum   |
|   |                                     | \$3,000   |             | \$3,000   | No Maximum   |
|   |                                     | \$3,000   |             | \$3,000   | No Maximum   |
| The Plan Pays   |                                     | The Plan Pays   |             | The Plan Pays   |  |
| Not Available   |                                     | Not Available   |             | Not Available   |  |
| The Plan Pays   |                                     | The Plan Pays   |             | The Plan Pays   |  |
| 80% coverage; subject to deductible   | 80% coverage; subject to deductible | 100% coverage after a \$25 PCP or \$50 SPC co-payment per visit       | No Coverage | 100% coverage after a \$10 AHN/\$20 PCP or \$35 AHN/\$45 SPC co-payment per visit | 50% coverage; subject to Out-of-Network Deductible |

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|   | Pelican HRA 1000                                   |  | Magnolia Local Plus   |               |
|---|--|--|---|---------------|
|   | Network  | Non-Network  | Network   | Non-Network   |
| <b>Physicians' Services</b>   | <b>The Plan Pays</b>                               |  | <b>The Plan Pays</b>  |               |
| <b>Maternity Care</b><br>(prenatal, delivery and postpartum)  | 80% coverage;<br>subject to deductible             | 60% coverage;<br>subject to deductible   | 100% coverage;<br>after a \$90 co-payment<br>per pregnancy  | No Coverage   |
| <b>Physician Services<br/>Furnished in a Hospital</b><br>Visits; surgery in general,<br>including charges by<br>surgeon, anesthesiologist,<br>pathologist and radiologist.                                    | 80% coverage;<br>subject to deductible             | 60% coverage;<br>subject to deductible   | 100% coverage   | No Coverage   |
| <b>Preventative Care<br/>Primary Care Physician or<br/>Specialist Office or Clinic</b><br>For a complete list of<br>benefits, refer to the<br>Preventive and Wellness/<br>Routine Care in the Benefit<br>Plan | 100% coverage;<br><b>not</b> subject to deductible | 100% of fee schedule<br>amount. Plan participant<br>pays the difference between<br>the billed amount and the<br>fee schedule amount; <b>not</b><br>subject to deductible | 100% coverage   | No Coverage   |
| <b>Physician Services for<br/>Emergency Room Care</b>   | 80% coverage;<br>subject to deductible             | 80% coverage;<br>subject to deductible   | 100% coverage   | 100% coverage |
| <b>Allergy Shots and Serum</b><br>Co-payment per visit is<br>applicable only to office<br>visit   | 80% coverage;<br>subject to deductible             | 60% coverage;<br>subject to deductible   | 100% coverage after a \$25<br>PCP or \$50 SPC per office<br>visit co-payment per visit;<br>shots and serum 100% | No Coverage   |
| <b>Outpatient Surgery/<br/>Services</b><br>When billed as office visits   | 80% coverage;<br>subject to deductible             | 60% coverage;<br>subject to deductible   | 100% coverage;<br>after a \$25 PCP or \$50 SPC<br>per office visit co-payment<br>per visit                      | No Coverage   |
| <b>Outpatient Surgery/<br/>Services</b><br>When billed as outpatient<br>surgery at a facility   | 80% coverage;<br>subject to deductible             | 60% coverage;<br>subject to deductible   | 100% coverage   | No Coverage   |
| <b>Hospital Services</b>  | <b>The Plan Pays</b>                               |  | <b>The Plan Pays</b>  |               |
| <b>Inpatient Services</b><br>Inpatient care, delivery and<br>inpatient short-term acute<br>rehabilitation services  | 80% coverage;<br>subject to deductible             | 60% coverage;<br>subject to deductible   | 100% coverage;<br>after a \$100 co-payment<br>per day max \$300 per<br>admission                                | No Coverage   |

**Retirees with Medicare (RETIREMENT DATE BEFORE March 1, 2015)**

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**Benefits effective January 1, 2016 - December 31, 2016**

| Magnolia Open Access                            |                                     | Magnolia Local   |               | Vantage Medical Home   |  |
|---|-------------------------------------|--|---------------|--|--|
| Network   | Non-Network                         | Network  | Non-Network   | Tier I Network   | Non-Network  |
| <b>The Plan Pays</b>                            |                                     | <b>The Plan Pays</b>   |               | <b>The Plan Pays</b>   |  |
| 80% coverage; subject to deductible             | 80% coverage; subject to deductible | 100% coverage; after a \$90 co-payment per pregnancy   | No Coverage   | 100% coverage after a \$10 AHN/\$20 co-payment per pregnancy   | 50% coverage; subject to Out-of-Network Deductible |
| 80% coverage; subject to deductible             | 80% coverage; subject to deductible | 100% coverage  | No Coverage   | 100% coverage; subject to Tier I deductible  | 50% coverage; subject to Out-of-Network Deductible |
| 100% coverage; <b>not</b> subject to deductible | 80% coverage; subject to deductible | 100% coverage  | No Coverage   | 100% coverage; <b>not</b> subject to deductible  | 50% coverage; subject to Out-of-Network Deductible |
| 80% coverage; subject to deductible             | 80% coverage; subject to deductible | 100% coverage  | 100% coverage | 100% coverage; subject to Tier I deductible  | 50% coverage; subject to Out-of-Network Deductible |
| 80% coverage; subject to deductible             | 80% coverage; subject to deductible | 100% coverage after a \$25 PCP or \$50 SPC per office visit co-payment per visit; shots and serum 100% | No Coverage   | 80% coverage; subject to Tier I deductible   | 50% coverage; subject to Out-of-Network deductible |
| 80% coverage; subject to deductible             | 80% coverage; subject to deductible | 100% coverage; after a \$25 PCP or \$50 SPC per office visit co-payment per visit                      | No Coverage   | 100% coverage after a \$10 AHN/\$20 PCP or \$35 AHN/\$45 SPC office visit co-payment per visit                       | 50% coverage; subject to Out-of-Network Deductible |
| 80% coverage; subject to deductible             | 80% coverage; subject to deductible | 100% coverage  | No Coverage   | 100% coverage; subject to Tier I deductible  | 50% coverage; subject to Out-of-Network Deductible |
| <b>The Plan Pays</b>                            |                                     | <b>The Plan Pays</b>   |               | <b>The Plan Pays</b>   |  |
| 80% coverage; subject to deductible             | 80% coverage; subject to deductible | 100% coverage; after a \$100 co-payment per day max \$300 per admission                                | No Coverage   | 100% coverage after a \$50 AHN/\$100 co-payment per day max \$150 AHN/\$300 per admission; not subject to deductible | 50% coverage; subject to Out-of-Network Deductible |

**Retirees with Medicare (RETIREMENT DATE BEFORE March 1, 2015)**

**Benefits Comparison**

**Benefits effective January 1, 2016 - December 31, 2016**

|  | Pelican HRA 1000                       |  | Magnolia Local Plus  |   |
|--|--|--|--|---|
|  | Network                                | Non-Network                            | Network  | Non-Network   |
| <b>Hospital Services</b>   | <b>The Plan Pays</b>                   |  | <b>The Plan Pays</b>   |   |
| <b>Outpatient Surgery/ Services</b><br>Hospital / Facility   | 80% coverage;<br>subject to deductible | 60% coverage;<br>subject to deductible | 100% coverage;<br>after a \$100 facility co-payment per visit              | No Coverage   |
| <b>Emergency Room Care - Hospital</b><br>Treatment of an emergency medical condition or injury   | 80% coverage;<br>subject to deductible | 80% coverage;<br>subject to deductible | 100% coverage after \$150 co-payment per visit;<br>waived if admitted      | 100% coverage after \$150 co-payment per visit;<br>waived if admitted |
| <b>Behavioral Health</b>   | <b>The Plan Pays</b>                   |  | <b>The Plan Pays</b>   |   |
| <b>Mental Health and Substance Abuse</b><br>Inpatient Facility   | 80% coverage;<br>subject to deductible | 60% coverage;<br>subject to deductible | 100% coverage;<br>after a \$100 co-payment per day max \$300 per admission | No Coverage   |
| <b>Mental Health and Substance Abuse</b><br>Outpatient Visits - Professional   | 80% coverage;<br>subject to deductible | 60% coverage;<br>subject to deductible | 100% coverage;<br>after a \$25 co-payment per visit                        | No Coverage   |
| <b>Other Coverage</b>  | <b>The Plan Pays</b>                   |  | <b>The Plan Pays</b>   |   |
| <b>Outpatient Acute Short-Term Rehabilitation Services</b><br>Physical Therapy, Speech Therapy, Occupational Therapy, Other short term rehabilitative services | 80% coverage;<br>subject to deductible | 60% coverage;<br>subject to deductible | 100% coverage;<br>after a \$25 co-payment per visit                        | No Coverage   |
| <b>Chiropractic Care</b>   | 80% coverage;<br>subject to deductible | 60% coverage;<br>subject to deductible | 100% coverage;<br>after a \$25 co-payment per visit                        | No Coverage   |
| <b>Hearing Aid</b><br>Not covered for individuals age eighteen (18) and older  | 80% coverage;<br>subject to deductible | No Coverage                            | 80% coverage   | No Coverage   |
| <b>Vision Exam (routine)</b>   | No Coverage                            | No Coverage                            | No Coverage  | No Coverage   |
| <b>Urgent Care Center</b>  | 80% coverage;<br>subject to deductible | 60% coverage;<br>subject to deductible | 100% coverage after a \$50 co-payment per visit                            | No Coverage   |
| <b>Home Health Care Services</b>   | 80% coverage;<br>subject to deductible | 60% coverage;<br>subject to deductible | 100% coverage  | No Coverage   |

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**Benefits effective January 1, 2016 - December 31, 2016**

| Magnolia Open Access  |   | Magnolia Local  |  | Vantage Medical Home   |   |
|---|---|---|--|--|---|
| Network   | Non-Network   | Network   | Non-Network  | Tier I Network   | Non-Network   |
| <b>The Plan Pays</b>  |   | <b>The Plan Pays</b>  |  | <b>The Plan Pays</b>   |   |
| 80% coverage; subject to deductible   | 80% coverage; subject to deductible   | 100% coverage; after a \$100 facility co-payment per visit              | No Coverage  | 100% coverage after a \$50 AHN/\$100 co-payment  | 50% coverage; subject to Out-of-Network Deductible                          |
| 80% coverage; subject to deductible; \$150 co-payment per visit; waived if admitted | 80% coverage; subject to deductible; \$150 co-payment per visit; waived if admitted | 100% coverage after \$150 co-payment per visit; waived if admitted      | 100% coverage after \$150 co-payment per visit; waived if admitted | 100% coverage after a \$150 co-payment per visit; waived if admitted   | 100% coverage after a \$150 co-payment per visit; not subject to deductible |
| <b>The Plan Pays</b>  |   | <b>The Plan Pays</b>  |  | <b>The Plan Pays</b>   |   |
| 80% coverage; subject to deductible   | 80% coverage; subject to deductible   | 100% coverage; after a \$100 co-payment per day max \$300 per admission | No Coverage  | 100% coverage after a \$50 AHN/\$100 co-payment per day max \$150 AHN/\$300 per admission; not subject to deductible | 50% coverage; subject to Out-of-Network Deductible                          |
| 80% coverage; subject to deductible   | 80% coverage; subject to deductible   | 100% coverage; after a \$25 co-payment per visit                        | No Coverage  | 100% coverage after a \$10 AHN/\$20 PCP or \$35 AHN/\$45 SPC co-payment per visit                                    | 50% coverage; subject to Out-of-Network Deductible                          |
| <b>The Plan Pays</b>  |   | <b>The Plan Pays</b>  |  | <b>The Plan Pays</b>   |   |
| 80% coverage; subject to deductible   | 80% coverage; subject to deductible   | 100% coverage; after a \$25 co-payment per visit                        | No Coverage  | 100% coverage after a \$10 AHN/\$20 co-payment per visit   | 50% coverage; subject to Out-of-Network Deductible                          |
| 80% coverage; subject to deductible   | 80% coverage; subject to deductible   | 100% coverage; after a \$25 co-payment per visit                        | No Coverage  | 100% coverage after a \$20 PCP co-payment per visit  | 50% coverage; subject to Out-of-Network Deductible                          |
| 80% coverage; subject to deductible   | 80% coverage; subject to deductible   | 80% coverage  | No Coverage  | 80% coverage; subject to Tier I deductible   | 50% coverage; subject to Out-of-Network Deductible                          |
| No Coverage   | No Coverage   | No Coverage   | No Coverage  | 100% coverage; after a \$35 AHN/\$45 co-payment per visit  | 50% coverage; subject to Out-of-Network Deductible                          |
| 80% coverage; subject to deductible   | 80% coverage; subject to deductible   | 100% coverage after a \$50 co-payment per visit                         | No Coverage  | 100% coverage; after a \$50 co-payment per visit   | 50% coverage; subject to Out-of-Network Deductible                          |
| No Coverage   | No Coverage   | 100% coverage   | No Coverage  | 100% coverage; subject to Tier I deductible  | No Coverage   |

**Retirees with Medicare (RETIREMENT DATE BEFORE March 1, 2015)**  
**Benefits Comparison**  
**Benefits effective January 1, 2016 - December 31, 2016**

|  | Pelican HRA 1000                                 |                                     | Magnolia Local Plus   |             |
|--|--|-------------------------------------|---|-------------|
|  | Network  | Non-Network                         | Network   | Non-Network |
| <b>Other Coverage</b>  | <b>The Plan Pays</b>                             |                                     | <b>The Plan Pays</b>  |             |
| <b>Skilled Nursing Facility Services</b>   | 80% coverage; subject to deductible              | 60% coverage; subject to deductible | 100% coverage; after a \$100 co-payment per day max \$300 per admission               | No Coverage |
| <b>Hospice Care</b>  | 80% coverage; subject to deductible              | 60% coverage; subject to deductible | 100% coverage   | No Coverage |
| <b>Durable Medical Equipment (DME) - Rental or Purchase</b>  | 80% coverage; subject to deductible              | 60% coverage; subject to deductible | 80% coverage of the first \$5,000 allowable; 100% in excess of \$5,000 per plan year; | No Coverage |
| <b>Transplant Services</b>   | 80% coverage; subject to deductible              | No Coverage                         | 100% coverage   | No Coverage |
| <b>Pharmacy</b>  | <b>You Pay</b>                                   |                                     | <b>You Pay</b>  |             |
| Tier 1 - Generic   | 50% up to \$30 <sup>1</sup>                      |                                     | 50% up to \$30 <sup>1</sup>   |             |
| Tier 2 - Preferred   | 50% up to \$55 <sup>1,2</sup>                    |                                     | 50% up to \$55 <sup>1,2</sup>   |             |
| Tier 3 - Non-Preferred   | 65% up to \$80 <sup>1,2</sup>                    |                                     | 65% up to \$80 <sup>1,2</sup>   |             |
| Tier 4 - Specialty   | 50% up to \$80 <sup>1,2</sup>                    |                                     | 50% up to \$80 <sup>1,2</sup>   |             |
| 90 day supply for maintenance drugs from mail order OR at participating 90-day retail network pharmacies | 2.5 times the cost of your applicable co-payment |                                     | 2.5 times the cost of your applicable co-payment                                      |             |
| <b>After the out-of-pocket threshold amount of \$1,500 is met:</b>                                       |  |                                     |   |             |
| Tier 1 - Generic   | \$0 co-payment <sup>1</sup>                      |                                     | \$0 co-payment <sup>1</sup>   |             |
| Tier 2 - Preferred   | \$20 co-payment <sup>1,2</sup>                   |                                     | \$20 co-payment <sup>1,2</sup>  |             |
| Tier 3 - Non-Preferred   | \$40 co-payment <sup>1,2</sup>                   |                                     | \$40 co-payment <sup>1,2</sup>  |             |
| Tier 4 - Specialty   | \$40 co-payment <sup>1,2</sup>                   |                                     | \$40 co-payment <sup>1,2</sup>  |             |

**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.

**Retirees with Medicare (RETIREMENT DATE BEFORE March 1, 2015)**

**Benefits Comparison**

**Benefits effective January 1, 2016 - December 31, 2016**

| Magnolia Open Access  |                                     | Magnolia Local   |             | Vantage Medical Home  |   |
|---|-------------------------------------|--|-------------|---|---|
| Network   | Non-Network                         | Network  | Non-Network | Tier I Network  | Non-Network   |
| <b>The Plan Pays</b>  |                                     | <b>The Plan Pays</b>   |             | <b>The Plan Pays</b>  |   |
| 80% coverage; subject to deductible                                 | 80% coverage; subject to deductible | 100% coverage; after a \$100 co-payment per day max \$300 per admission              | No Coverage | 100% coverage after \$50 AHN/\$100 co-payment per day max \$150 AHN/\$300 per admission; not subject to deductible  | 50% coverage; subject to Out-of-Network Deductible          |
| No Coverage   | No Coverage                         | 100% coverage  | No Coverage | 100% coverage; subject to Tier I deductible   | No Coverage   |
| 80% coverage; subject to deductible                                 | 80% coverage; subject to deductible | 80% coverage of the first \$5,000 allowable; 100% in excess of \$5,000 per plan year | No Coverage | 80% coverage of the first \$5,000 allowable; 100% in excess of \$5,000 per plan year; subject to Tier I deductible  | 50% coverage; subject to Out-of-Network deductible          |
| 80% coverage; subject to deductible                                 | 80% coverage; subject to deductible | 100% coverage  | No Coverage | 100% coverage after \$100 copayment per day, max \$300 per admission; subject to Tier I deductible  | No Coverage   |
| <b>You Pay</b>  |                                     | <b>You Pay</b>   |             | <b>You Pay</b>  |   |
| 50% up to \$30 <sup>1</sup>   |                                     | 50% up to \$30 <sup>1</sup>  |             | Tier 1 - Preferred Generics<br>Tier 2 - Non-Preferred Generics  | \$5 co-payment <sup>3</sup><br>\$20 co-payment <sup>3</sup> |
| 50% up to \$55 <sup>1,2</sup>                                       |                                     | 50% up to \$55 <sup>1,2</sup>  |             | Tier 3 - Preferred Brand  | \$50 co-payment <sup>2,3</sup>                              |
| 65% up to \$80 <sup>1,2</sup>                                       |                                     | 65% up to \$80 <sup>1,2</sup>  |             | Tier 4 - Non-Preferred Brand  | \$80 co-payment <sup>2,3</sup>                              |
| 50% up to \$80 <sup>1,2</sup>                                       |                                     | 50% up to \$80 <sup>1,2</sup>  |             | Tier 5 - Specialty  | \$150 co-payment <sup>2,3</sup>                             |
| 2.5 times the cost of your applicable co-payment                    |                                     | 2.5 times the cost of your applicable co-payment                                     |             | Tier I Preferred Generics \$0 AHN co-pay; 30-day supply for 1 co-pay; 60-day supply for 2 co-pays; 90-day supply for 3 co-pays – All tiers but Tier 5 Specialty |   |
| <b>After the out-of-pocket threshold amount of \$1,500 is met*:</b> |                                     |  |             |   |   |
| \$0 co-payment <sup>1</sup>   |                                     | \$0 co-payment <sup>1</sup>  |             | N/A   |   |
| \$20 co-payment <sup>1,2</sup>                                      |                                     | \$20 co-payment <sup>1,2</sup>   |             | N/A   |   |
| \$40 co-payment <sup>1,2</sup>                                      |                                     | \$40 co-payment <sup>1,2</sup>   |             | N/A   |   |
| \$40 co-payment <sup>1,2</sup>                                      |                                     | \$40 co-payment <sup>1,2</sup>   |             | N/A   |   |

<sup>1</sup> Prescription drug benefit - 31 day fill

<sup>2</sup> Member who chooses brand-name drug for which approved generic version is available pays cost difference between brand-name drug & generic drug, plus co-pay for brand-name drug; cost difference does not apply to \$1,500 out-of-pocket threshold (if applicable).

<sup>3</sup> Prescription drug benefit - 30 day fill

\* \$1,500 threshold does not apply to Vantage Medical Home HMO pharmacy benefits