

Non-Medicare Retirees
(RETIREMENT DATE BEFORE March 1, 2015)
Benefits Comparison
Benefits effective January 1, 2017 - December 31, 2017

	Pelican HRA1000		Magnolia Local Plus	
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	Non-Medicare Retirees (retirement date BEFORE 3-1-15)		Non-Medicare Retirees (retirement date BEFORE 3-1-15)	
	Network	Non-Network	Network	Non-Network
	You Pay		You Pay	
	Deductible			
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			
	Out-of-Pocket Maximum			
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	
State Funding	The Plan Pays		The Plan Pays	
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.			
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	100% coverage after a \$25 PCP or \$50 SPC copayment per visit	No Coverage

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

Benefits Comparison

Benefits effective January 1, 2017 - December 31, 2017

Magnolia Open Access		Magnolia Local		Vantage Medical Home HMO	
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) and Out-of-Network	
Non-Medicare Retirees (retirement date BEFORE 3-1-15)		Non-Medicare Retirees (retirement date BEFORE 3-1-15)		Non-Medicare Retirees (retirement date BEFORE 3-1-15)	
Network	Non-Network	Network	Non-Network	Network	Non-Network
You Pay		You Pay		You Pay	
Deductible					
\$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					
\$1,300 individual; plus \$1,300 per additional person up to 2; plus \$1,000 per additional person up to 10 people; \$12,700 for a family of 12+	\$3,300 individual; plus \$3,000 per additional person up to 2; \$12,700 for a family of 4+	\$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	
90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a \$25 PCP or \$50 SPC copayment per visit	No Coverage	100% coverage after a \$10 AHN/\$20 PCP or \$35 AHN/\$45 SPC copayment per visit	50% coverage; subject to Out-of-Network Deductible

Non-Medicare Retirees
(RETIREMENT DATE BEFORE March 1, 2015)
Benefits Comparison
Benefits effective January 1, 2017 - December 31, 2017

	Pelican HRA1000		Magnolia Local Plus	
	Network	Non-Network	Network	Non-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	100% coverage; after a \$90 copayment per pregnancy	No Coverage
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	100% coverage	No Coverage
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	No Coverage
Physician Services for Emergency Room Care	80% coverage; subject to deductible	80% coverage; subject to deductible	100% coverage	100% coverage
Allergy Shots and Serum Copayment per visit is applicable only to office visit	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after a \$25 PCP or \$50 SPC per office visit copayment per visit; shots and serum 100%	No Coverage
Outpatient Surgery/Services When billed as office visits	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; after a \$25 PCP or \$50 SPC per office visit copayment per visit	No Coverage
Outpatient Surgery/Services When billed as outpatient surgery at a facility	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage	No Coverage
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	100% coverage; after a \$100 copayment per day max \$300 per admission	No Coverage

Non-Medicare Retirees
(RETIREMENT DATE BEFORE March 1, 2015)

Benefits Comparison

Benefits effective January 1, 2017 - December 31, 2017

Magnolia Open Access		Magnolia Local		Vantage Medical Home HMO	
Network	Non-Network	Network	Non-Network	Network	Non-Network
The Plan Pays		The Plan Pays		The Plan Pays	
90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a \$90 copayment per pregnancy	No Coverage	100% coverage after a \$10 AHN/\$20 copayment per pregnancy	50% coverage; subject to Out-of-Network Deductible
90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage	No Coverage	100% coverage	50% coverage; subject to Out-of-Network Deductible
100% coverage; not subject to deductible	70% coverage; subject to deductible	100% coverage	No Coverage	100% coverage	50% coverage; subject to Out-of-Network Deductible
90% coverage; subject to deductible	90% coverage; subject to deductible	100% coverage	100% coverage	100% coverage	50% coverage; subject to Out-of-Network Deductible
90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a \$25 PCP or \$50 SPC per office visit copayment per visit; shots and serum 100%	No Coverage	80% coverage	50% coverage; subject to Out-of-Network Deductible
90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a \$25 PCP or \$50 SPC per office visit copayment per visit	No Coverage	100% coverage after a \$10 AHN/\$20 PCP or \$35 AHN/\$45 SPC office visit copayment per visit	50% coverage; subject to Out-of-Network Deductible
90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage	No Coverage	100% coverage	50% coverage; subject to Out-of-Network Deductible
The Plan Pays		The Plan Pays		The Plan Pays	
90% coverage; subject to deductible	70% coverage; subject to deductible + \$50 copayment per day (days 1 - 5)	100% coverage; after a \$100 copayment per day max \$300 per admission	No Coverage	100% coverage after a \$50 AHN/\$100 copayment per day max \$150 AHN/\$300 per admission	50% coverage; subject to Out-of-Network Deductible

Non-Medicare Retirees
(RETIREMENT DATE BEFORE March 1, 2015)
Benefits Comparison
Benefits effective January 1, 2017 - December 31, 2017

	Pelican HRA 1000		Magnolia Local Plus	
	Network	Non-Network	Network	Non-Network
Hospital Services	The Plan Pays		The Plan Pays	
Outpatient Surgery/Services Hospital / Facility	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; after a \$100 facility copayment per visit	No Coverage
Emergency Room - Hospital (Facility) Treatment of an emergency medical condition or injury	80% coverage; subject to deductible	80% coverage; subject to deductible	100% coverage after \$150 copayment per visit; waived if admitted	100% coverage after \$150 copayment per visit; waived if admitted
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	100% coverage; after a \$100 copayment per day max \$300 per admission	No Coverage
Mental Health and Substance Abuse Outpatient Visits - Professional	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; after a \$25 copayment per visit	No Coverage
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	100% coverage; after a \$25 copayment per visit	No Coverage
Chiropractic Care	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; after a \$25 copayment per visit	No Coverage
Hearing Aid Not covered for individuals age eighteen (18) and older	80% coverage; subject to deductible	No Coverage	80% coverage	No Coverage
Vision Exam (routine)	No Coverage	No Coverage	No Coverage	No Coverage
Urgent Care Center	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after a \$50 copayment per visit	No Coverage
Home Health Care Services	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage	No Coverage

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

**Benefits Comparison
Benefits effective January 1, 2017 - December 31, 2017**

Magnolia Open Access		Magnolia Local		Vantage Medical Home HMO	
Network	Non-Network	Network	Non-Network	Network	Non-Network
The Plan Pays		The Plan Pays		The Plan Pays	
90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a \$100 facility copayment per visit	No Coverage	100% coverage after a \$50 AHN/\$100 copayment	50% coverage; subject to Out-of-Network Deductible
90% coverage; subject to deductible; \$150 copayment per visit; waived if admitted	90% coverage; subject to deductible; \$150 copayment per visit; waived if admitted	100% coverage after \$150 copayment per visit; waived if admitted	100% coverage after \$150 copayment per visit; waived if admitted	100% coverage after a \$150 copayment per visit; waived if admitted	100% coverage after a \$150 copayment per visit; not subject to deductible
The Plan Pays		The Plan Pays		The Plan Pays	
90% coverage; subject to deductible	70% coverage; subject to deductible + \$50 copayment per day (days 1-5)	100% coverage; after a \$100 copayment per day max \$300 per admission	No Coverage	100% coverage after a \$50 AHN/\$100 copayment per day max \$150 AHN/\$300 per admission	50% coverage; subject to Out-of-Network Deductible
90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a \$25 copayment per visit	No Coverage	100% coverage after a \$10 AHN/\$20 PCP or \$35 AHN/\$45 SPC copayment per visit	50% coverage; subject to Out-of-Network Deductible
The Plan Pays		The Plan Pays		The Plan Pays	
90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a \$25 copayment per visit	No Coverage	100% coverage after a \$10 AHN/\$20 copayment per visit	50% coverage; subject to Out-of-Network Deductible
90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a \$25 copayment per visit	No Coverage	100% coverage after a \$20 PCP copayment per visit	50% coverage; subject to Out-of-Network Deductible
90% coverage; subject to deductible	70% coverage; subject to deductible	80% coverage	No Coverage	80% coverage	50% coverage; subject to Out-of-Network Deductible
No Coverage	No Coverage	No Coverage	No Coverage	100% coverage; after a \$35 AHN/\$45 copayment per visit	50% coverage; subject to Out-of-Network Deductible
90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a \$50 copayment per visit	No Coverage	100% coverage; after a \$50 copayment per visit	50% coverage; subject to Out-of-Network Deductible
90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage	No Coverage	100% coverage	No Coverage

Non-Medicare Retirees
(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
Other Coverage	The Plan Pays		The Plan Pays	
Skilled Nursing Facility Services	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
Hospice Care	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage	No Coverage
Durable Medical Equipment (DME) - Rental or Purchase	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
Transplant Services	80% coverage; subject to deductible	No Coverage	100% coverage	No Coverage
Pharmacy	You Pay		You Pay	
Tier 1 - Generic	50% up to \$30 ¹		50% up to \$30 ¹	
Tier 2 - Preferred	50% up to \$55 ^{1,2}		50% up to \$55 ^{1,2}	
Tier 3 - Non-Preferred	65% up to \$80 ^{1,2}		65% up to \$80 ^{1,2}	
Tier 4 - Specialty	50% up to \$80 ^{1,2}		50% up to \$80 ^{1,2}	
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 co-payment		2.5 times the cost of applicable maximum co-payment	
After the out-of-pocket threshold amount of \$1,500 is met by you and/or your covered dependent(s):				
Tier 1 - Generic	\$0 co-payment ¹		\$0 co-payment ¹	
Tier 2 - Preferred	\$20 co-payment ^{1,2}		\$20 co-payment ^{1,2}	
Tier 3 - Non-Preferred	\$40 co-payment ^{1,2}		\$40 co-payment ^{1,2}	
Tier 4 - Specialty	\$40 co-payment ^{1,2}		\$40 co-payment ^{1,2}	
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.				

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

**Benefits Comparison
Benefits effective January 1, 2017 - December 31, 2017**

Magnolia Open Access		Magnolia Local		Vantage Medical Home	
Network	Non-Network	Network	Non-Network	Network	Non-Network
The Plan Pays		The Plan Pays		The Plan Pays	
90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a \$100 copayment per day max \$300 per admission	No Coverage	100% coverage after \$100 copayment per day max \$300 per admission	50% coverage; subject to Out-of-Network Deductible
80% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage	No Coverage	100% coverage	No Coverage
90% coverage; subject to deductible	70% 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	50% coverage; subject to Out-of-Network Deductible
90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage	No Coverage	100% coverage after \$100 copayment per day, max \$300 per admission	No Coverage
You Pay		You Pay		You Pay	
50% up to \$30 ¹		50% up to \$30 ¹		Tier 1 - Preferred Generics Tier 2 - Non-Preferred Generics	\$5 copayment ³ \$20 copayment ³
50% up to \$55 ^{1,2}		50% up to \$55 ^{1,2}		Tier 3 - Preferred Brand	\$50 copayment ^{2,3}
65% up to \$80 ^{1,2}		65% up to \$80 ^{1,2}		Tier 4 - Non-Preferred Brand	\$80 copayment ^{2,3}
50% up to \$80 ^{1,2}		50% up to \$80 ^{1,2}		Tier 5 - Specialty	\$150 copayment ^{2,3}
2.5 times the cost of applicable maximum copayment		2.5 times the cost of applicable maximum copayment		Tier 1 Preferred Generics: \$0 AHN copay; Tiers 2-4: 3 copays; Tier 5 Specialty: 90-day mail-order not available	
After the out-of-pocket threshold amount of \$1,500 is met by you and/or your covered dependent(s)*:					
\$0 copayment ¹		\$0 copayment ¹		N/A	
\$20 copayment ^{1,2}		\$20 copayment ^{1,2}		N/A	
\$40 copayment ^{1,2}		\$40 copayment ^{1,2}		N/A	
\$40 copayment ^{1,2}		\$40 copayment ^{1,2}		N/A	

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

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