

Non-Medicare Retirees
(RETIREMENT DATE BEFORE March 1, 2015)
Benefits Comparison
Benefits effective January 1, 2018 - December 31, 2018

| | 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 | \$2,000 | No Coverage |
| You + 1 (Spouse or child) | \$10,000 | \$20,000 | \$3,000 | |
| You + Children | \$10,000 | \$20,000 | \$4,000 | |
| You + Family | \$10,000 | \$20,000 | \$4,000 | |
| 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, 2018 - December 31, 2018

| 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 | | Affinity Health Network "AHN" and standard In-Network 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 | | | | | |
| \$2,300 individual; plus \$1,300 per additional person up to 2; plus \$1,000 per additional person up to 10 people; \$13,700 for a family of 11+ | \$4,300 individual; plus \$3,000 per additional person up to 2; \$13,700 for a family of 3+ | \$1,000 | No Coverage | \$2,000 | No Maximum |
| | | \$2,000 | | \$3,000 | No Maximum |
| | | \$3,000 | | \$4,000 | No Maximum |
| | | \$3,000 | | \$4,000 | 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 |

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(RETIREMENT DATE BEFORE March 1, 2015)
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Benefits effective January 1, 2018 - December 31, 2018

| | 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, 2018 - December 31, 2018

| 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, 2018 - December 31, 2018

| | 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 \$200 copayment per visit; waived if admitted | 100% coverage after \$200 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, 2018 - December 31, 2018

| 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 \$200 copayment per visit; waived if admitted | 100% coverage after a \$200 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, 2018 - December 31, 2018**

| 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 | \$5 copayment ³ |
| 50% up to \$55 ^{1,2} | | 50% up to \$55 ^{1,2} | | Tier 2 - Non-Preferred Generics | \$20 copayment ³ |
| 65% up to \$80 ^{1,2} | | 65% up to \$80 ^{1,2} | | Tier 3 - Preferred Brand | \$50 copayment ^{2,3} |
| 50% up to \$80 ^{1,2} | | 50% up to \$80 ^{1,2} | | Tier 4 - Non-Preferred Brand | \$80 copayment ^{2,3} |
| 2.5 times the cost of applicable maximum copayment | | 2.5 times the cost of applicable maximum copayment | | 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