

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

	<b>Pelican HRA1000</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 (retirement date BEFORE 3/1/2015)		Medicare Retirees (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	\$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	
<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 copayment per visit	No Coverage

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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	
Medicare Retirees (retirement date BEFORE 3/1/2015)		Medicare Retirees (retirement date BEFORE 3/1/2015)		Medicare Retirees	
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					
\$3,300 individual; plus \$2,300 per additional person up to 2; plus \$2,000 per additional person up to 2 additional people; \$13,700 for a family of 5+		\$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	
80% coverage; subject to deductible	80% 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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	Network	Non-Network	Network	Non-Network
<b>Physicians' Services</b>	<b>The Plan Pays</b>		<b>The Plan Pays</b>	
<b>Maternity Care</b> (prenatal, delivery and postpartum)	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; after a \$90 copayment per pregnancy	No Coverage
<b>Physician Services Furnished in a Hospital</b> 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
<b>Preventative Care Primary Care Physician or Specialist Office or Clinic</b> For a complete list of benefits, refer to the Preventive and Wellness/ Routine Care in the Benefit Plan	100% coverage; <b>not</b> subject to deductible	100% of fee schedule amount. Plan participant pays the difference between the billed amount and the fee schedule amount; <b>not</b> subject to deductible	100% coverage	No Coverage
<b>Physician Services for Emergency Room Care</b>	80% coverage; subject to deductible	80% coverage; subject to deductible	100% coverage	100% coverage
<b>Allergy Shots and Serum</b> 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
<b>Outpatient Surgery/ Services</b> 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
<b>Outpatient Surgery/ Services</b> When billed as outpatient surgery at a facility	80% coverage; subject to deductible	60% coverage; 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> 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

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Magnolia Open Access		Magnolia Local		Vantage Medical Home HMO	
Network	Non-Network	Network	Non-Network	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 copayment per pregnancy	No Coverage	100% coverage after a \$10 AHN/\$20 copayment 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	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	50% coverage; subject to Out-of-Network Deductible
80% coverage; subject to deductible	80% coverage; subject to deductible	100% coverage	100% coverage	100% coverage	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 copayment per visit; shots and serum 100%	No Coverage	80% coverage	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 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
80% coverage; subject to deductible	80% coverage; subject to deductible	100% coverage	No Coverage	100% coverage	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 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

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	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> Hospital / Facility	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; after a \$100 facility copayment per visit	No Coverage
<b>Emergency Room - Hospital (Facility)</b> 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
<b>Behavioral Health</b>	<b>The Plan Pays</b>		<b>The Plan Pays</b>	
<b>Mental Health and Substance Abuse</b> 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
<b>Mental Health and Substance Abuse</b> Outpatient Visits - Professional	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; after a \$25 copayment 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> 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
<b>Chiropractic Care</b>	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; after a \$25 copayment per visit	No Coverage
<b>Hearing Aid</b> Not covered for individuals age eighteen (18) and older	80% coverage; 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; subject to deductible	60% coverage; subject to deductible	100% coverage after a \$50 copayment per visit	No Coverage
<b>Home Health Care Services</b>	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage	No Coverage

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Network	Non-Network	Network	Non-Network	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 copayment per visit	No Coverage	100% coverage after a \$50 AHN/\$100 copayment	50% coverage; subject to Out-of-Network Deductible
80% coverage; subject to deductible; \$150 copayment per visit; waived if admitted	80% 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
<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 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
80% coverage; subject to deductible	80% 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
<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 copayment per visit	No Coverage	100% coverage after a \$10 AHN/\$20 copayment 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 copayment per visit	No Coverage	100% coverage after a \$20 PCP copayment 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	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
80% coverage; subject to deductible	80% 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
No Coverage	No Coverage	100% coverage	No Coverage	100% coverage	No Coverage

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<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 copayment 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 applicable maximum copayment		2.5 times the cost of applicable maximum copayment	
<b>After the out-of-pocket threshold amount of \$1,500 is met by you and/or your covered dependent(s):</b>				
Tier 1 - Generic	\$0 copayment <sup>1</sup>		\$0 copayment <sup>1</sup>	
Tier 2 - Preferred	\$20 copayment <sup>1,2</sup>		\$20 copayment <sup>1,2</sup>	
Tier 3 - Non-Preferred	\$40 copayment <sup>1,2</sup>		\$40 copayment <sup>1,2</sup>	
Tier 4 - Specialty	\$40 copayment <sup>1,2</sup>		\$40 copayment <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.

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Network	Non-Network	Network	Non-Network	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 copayment per day max \$300 per admission	No Coverage	100% coverage after \$50 AHN/\$100 copayment per day max \$150 AHN/\$300 per admission	50% coverage; subject to Out-of-Network Deductible
No Coverage	No Coverage	100% coverage	No Coverage	100% coverage	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	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	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	\$5 copayment <sup>3</sup>
50% up to \$55 <sup>1,2</sup>		50% up to \$55 <sup>1,2</sup>		Tier 2 - Non-Preferred Generics	\$20 copayment <sup>3</sup>
65% up to \$80 <sup>1,2</sup>		65% up to \$80 <sup>1,2</sup>		Tier 3 - Preferred Brand	\$50 copayment <sup>2,3</sup>
50% up to \$80 <sup>1,2</sup>		50% up to \$80 <sup>1,2</sup>		Tier 4 - Non-Preferred Brand	\$80 copayment <sup>2,3</sup>
2.5 times the cost of applicable maximum copayment		2.5 times the cost of applicable maximum copayment		Tier 5 - Specialty	\$150 copayment <sup>2,3</sup>
2.5 times the cost of applicable maximum copayment		2.5 times the cost of applicable maximum copayment		Tier I Preferred Generics: \$0 AHN copay; Tiers 2-4: 3 copays; Tier 5 Specialty: 90-day mail-order not available	
<b>After the out-of-pocket threshold amount of \$1,500 is met by you and/or your covered dependent(s)*:</b>					
\$0 copayment <sup>1</sup>		\$0 copayment <sup>1</sup>		N/A	
\$20 copayment <sup>1,2</sup>		\$20 copayment <sup>1,2</sup>		N/A	
\$40 copayment <sup>1,2</sup>		\$40 copayment <sup>1,2</sup>		N/A	
\$40 copayment <sup>1,2</sup>		\$40 copayment <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 copay 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