

Retirees with Medicare
(RETIREMENT DATE ON or AFTER 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	Medicare Retirees (retirement date ON or AFTER 3/1/2015)		Medicare Retirees (retirement date ON or AFTER 3/1/2015)	
	Network	Non-Network	Network	Non-Network
	You Pay		You Pay	
	Deductible			
You	\$2,000	\$4,000	\$400	No Coverage
You + 1 (Spouse or child)	\$4,000	\$8,000	\$800	No Coverage
You + Children	\$4,000	\$8,000	\$1,200	No Coverage
You + Family	\$4,000	\$8,000	\$1,200	No Coverage
	HRA dollars will reduce this amount			
	Out-of-Pocket Maximum			
You	\$5,000	\$10,000	\$3,500	No Coverage
You + 1 (Spouse or child)	\$10,000	\$20,000	\$6,000	No Coverage
You + Children	\$10,000	\$20,000	\$8,500	No Coverage
You + Family	\$10,000	\$20,000	\$8,500	No Coverage
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

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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	
Medicare Retirees (retirement date ON or AFTER 3/1/2015)		Medicare Retirees (retirement date ON or AFTER 3/1/2015)		Medicare Retirees (retirement date ON or AFTER 3/1/2015)	
Network	Non-Network	Network	Non-Network	Network	Non-Network
You Pay		You Pay		You Pay	
Deductible					
\$900	\$900	\$400	No Coverage	\$400	\$1,500
\$1,800	\$1,800	\$800	No Coverage	\$800	\$3,000
\$2,700	\$2,700	\$1,200	No Coverage	\$1,200	\$4,500
\$2,700	\$2,700	\$1,200	No Coverage	\$1,200	\$4,500
Out-of-Pocket Maximum					
\$3,500	\$4,700	\$2,500	No Coverage	\$3,500	No Maximum
\$6,000	\$8,500	\$5,000	No Coverage	\$6,000	No Maximum
\$8,500	\$12,250	\$7,500	No Coverage	\$8,500	No Maximum
\$8,500	\$12,250	\$7,500	No Coverage	\$8,500	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
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; subject to deductible	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; not subject to deductible	No Coverage
Physician Services for Emergency Room Care	80% coverage; subject to deductible	80% coverage; subject to deductible	100% coverage; subject to deductible	100% coverage; subject to deductible
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% after deductible	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; subject to deductible	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

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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	
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; subject to deductible	No Coverage	100% coverage; subject to In- Network deductible	50% coverage; subject to Out-of- Network Deductible
100% coverage; not subject to deductible	80% coverage; subject to deductible	100% coverage; not subject to deductible	No Coverage	100% coverage; not subject to deductible	50% coverage; subject to Out-of- Network Deductible
80% coverage; subject to deductible	80% coverage; subject to deductible	100% coverage; subject to deductible	100% coverage; subject to deductible	100% coverage; subject to In- Network 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 copayment per visit; shots and serum 100% after deductible	No Coverage	80% coverage; subject to In- Network 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 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; subject to deductible	No Coverage	100% coverage; subject to In- Network deductible	50% coverage; subject to Out-of- Network Deductible
The Plan Pays		The Plan Pays		The Plan Pays	
80% coverage; subject to deductible	80% 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; not subject to deductible	50% coverage; subject to Out-of- Network Deductible

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	Pelican HRA1000		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; subject to deductible	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 subject to deductible	No Coverage

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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	
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; not subject to deductible	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
The Plan Pays		The Plan Pays		The Plan Pays	
80% coverage; subject to deductible	80% 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; 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 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	
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; subject to deductible	No Coverage	80% coverage; subject to In-Network deductible	50% coverage; subject to Out-of-Network Deductible
No Coverage	No Coverage	No Coverage	No Coverage	100% coverage; after a \$35AHN/\$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 subject to deductible	No Coverage	100% coverage; subject to In-Network deductible	No Coverage

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	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 copayment per day max \$300 per admission	No Coverage
Hospice Care	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; subject to deductible	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; subject to deductible; 100% in excess of \$5,000 per plan year	No Coverage
Transplant Services	80% coverage; subject to deductible	No Coverage	100% coverage; subject to deductible	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 copayment		2.5 times the cost of applicable maximum copayment	
After the out-of-pocket threshold amount of \$1,500 is met by you and/or your covered dependent(s):				
Tier 1 - Generic	\$0 copayment ¹		\$0 copayment ¹	
Tier 2 - Preferred	\$20 copayment ^{1,2}		\$20 copayment ^{1,2}	
Tier 3 - Non-Preferred	\$40 copayment ^{1,2}		\$40 copayment ^{1,2}	
Tier 4 - Specialty	\$40 copayment ^{1,2}		\$40 copayment ^{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.

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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	
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 \$100 copayment per day, max \$300 per admission; not subject to deductible	50% coverage; subject to Out-of-Network deductible
No Coverage	No Coverage	100% coverage; subject to deductible	No Coverage	100% coverage; subject to In-Network deductible	No Coverage
80% coverage; subject to deductible	80% 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	80% coverage of the first \$5,000 allowable; 100% in excess of \$5,000 per plan year; subject to In-Network deductible	50% coverage; subject to Out-of-Network Deductible
80% coverage; subject to deductible	80% coverage; subject to deductible	100% coverage; subject to deductible	No Coverage	100% coverage after \$100 copayment per day, max \$300 per admission; subject to In-Network deductible	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	\$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 I 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