

**Active Employees and Non-Medicare Retirees**  
**(RETIREMENT DATE ON or AFTER March 1, 2015)**  
**Benefits Comparison**  
**Benefits effective January 1, 2024 - December 31, 2024**

	Pelican HRA1000		Pelican HSA775	
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	Active Employees & Non-Medicare Retirees (retirement date on or AFTER 3-1-2015)		Active Employees	
	Network	Out-of-Network	Network	Out-of-Network
	You Pay		You Pay	
<b>Deductible</b>				
You	\$2,000	\$4,000	\$2,000	\$4,000
You + 1 (Spouse or child)	\$4,000	\$8,000	\$4,000	\$8,000
You + Children	\$4,000	\$8,000	\$4,000	\$8,000
You + Family	\$4,000	\$8,000	\$4,000	\$8,000
	HRA dollars will reduce this amount		HSA dollars will reduce this amount	
<b>Out-of-Pocket Maximum</b>				
You	\$5,000	\$10,000	\$5,000	\$10,000
You + 1 (Spouse or child)	\$10,000	\$20,000	\$10,000	\$20,000
You + Children	\$10,000	\$20,000	\$10,000	\$20,000
You + Family	\$10,000	\$20,000	\$10,000	\$20,000
<b>State Funding</b>	The Plan Pays		The Plan Pays	
You	\$1,000		\$775*	
You + 1 (Spouse or child)	\$2,000		\$775*	
You + Children	\$2,000		\$775*	
You + Family	\$2,000		\$775*	
	Funding not applicable to Pharmacy Expenses.		*\$200, plus up to \$575 more dollar for dollar match of employee contributions <sup>5</sup>	
<b>Physicians' Services</b>	The Plan Pays		The Plan Pays	
<b>Primary Care Physician or Specialist Office - Treatment of illness or injury</b>	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible

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Magnolia Local Plus		Magnolia Open Access		Magnolia Local	
Blue Cross and Blue Shield of Louisiana Preferred Care Provider & Blue Cross National Providers		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	
Active Employees & Non-Medicare Retirees (retirement date on or AFTER 3-1-2015)		Active Employees & Non-Medicare Retirees (retirement date on or AFTER 3-1-2015)		Active Employees & Non-Medicare Retirees (retirement date on or AFTER 3-1-2015)	
Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
You Pay		You Pay		You Pay	
Deductible					
\$400	No Coverage	\$900	\$900	\$400	No Coverage
\$800	No Coverage	\$1,800	\$1,800	\$800	No Coverage
\$1,200	No Coverage	\$2,700	\$2,700	\$1,200	No Coverage
\$1,200	No Coverage	\$2,700	\$2,700	\$1,200	No Coverage
Out-of-Pocket Maximum					
\$3,500	No Coverage	\$3,500	\$4,700	\$3,500	No Coverage
\$6,000	No Coverage	\$6,000	\$8,500	\$6,000	No Coverage
\$8,500	No Coverage	\$8,500	\$12,250	\$8,500	No Coverage
\$8,500	No Coverage	\$8,500	\$12,250	\$8,500	No Coverage
The Plan Pays		The Plan Pays		The Plan Pays	
Not Available		Not Available		Not Available	
The Plan Pays		The Plan Pays		The Plan Pays	
100% coverage after a \$25 PCP or \$50 SPC copay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a \$25 PCP or \$50 SPC copay per visit	No Coverage

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	Pelican HRA1000		Pelican HSA775	
	Network	Out-of-Network	Network	Out-of-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	80% coverage; subject to deductible	60% coverage; subject to deductible
<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	80% coverage; subject to deductible	60% coverage; subject to deductible
<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; <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
<b>Physician Services for Emergency Room Care</b>	80% coverage; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible
<b>Allergy Shots and Serum</b> Copay per visit is applicable only to office visit	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Outpatient Surgery/ Services</b> When billed as office visits	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Outpatient Surgery/ Services</b> When billed as outpatient surgery at a facility	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
<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	80% coverage; subject to deductible	60% coverage; subject to deductible

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**Benefits Comparison**

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Magnolia Local Plus		Magnolia Open Access		Magnolia Local	
Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
<b>The Plan Pays</b>		<b>The Plan Pays</b>		<b>The Plan Pays</b>	
100% coverage; after a \$90 copay per pregnancy	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a \$90 copay per pregnancy	No Coverage
100% coverage; subject to deductible	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; subject to deductible	No Coverage
100% coverage; <b>not</b> subject to deductible	No Coverage	100% coverage; <b>not</b> subject to deductible	70% coverage; subject to deductible	100% coverage; <b>not</b> subject to deductible	No Coverage
100% coverage; subject to deductible	100% coverage; subject to deductible	90% coverage; subject to deductible	90% coverage; subject to deductible	100% coverage; subject to deductible	100% coverage; subject to deductible
100% coverage after a \$25 PCP or \$50 SPC per office visit copay per visit; shots and serum 100% after deductible	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a \$25 PCP or \$50 SPC per office visit copay per visit; shots and serum 100% after deductible	No Coverage
100% coverage; after a \$25 PCP or \$50 SPC per office visit copay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a \$25 PCP or \$50 SPC per office visit copay per visit	No Coverage
100% coverage; subject to deductible	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; subject to deductible	No Coverage
<b>The Plan Pays</b>		<b>The Plan Pays</b>		<b>The Plan Pays</b>	
100% coverage; after a \$100 copay per day max \$300 per admission	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible + \$50 copay per day (days 1 - 50)	100% coverage; after a \$100 copay per day max \$300 per admission	No Coverage

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	Pelican HRA1000		Pelican HSA775	
	Network	Out-of-Network	Network	Out-of-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	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Emergency Room - Hospital</b> (Facility) Treatment of an emergency medical condition or injury	80% coverage; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible
<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	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Mental Health and Substance Abuse</b> Outpatient Visits - Professional	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
<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	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Chiropractic Care</b>	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Hearing Aid</b> Not covered for individuals age eighteen (18) and older	80% coverage; subject to deductible	No Coverage	80% coverage; subject to deductible	No Coverage
<b>Vision Exam (routine) and Eye Wear</b>	No Coverage	No Coverage	No Coverage	No Coverage
<b>Comprehensive Dental</b>	No Coverage	No Coverage	No Coverage	No Coverage
<b>Urgent Care Center</b>	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Home Health Care Services</b>	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible

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Magnolia Local Plus		Magnolia Open Access		Magnolia Local	
Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
<b>The Plan Pays</b>		<b>The Plan Pays</b>		<b>The Plan Pays</b>	
100% coverage; after a \$100 facility copay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a \$100 facility copay per visit	No Coverage
100% coverage after \$200 copay per visit; waived if admitted	100% coverage after \$200 copay per visit; waived if admitted	90% coverage; subject to deductible; \$200 copay per visit; waived if admitted	90% coverage; subject to deductible; \$200 copay per visit; waived if admitted	100% coverage after \$200 copay per visit; waived if admitted	100% coverage after \$200 copay per visit; waived if admitted
<b>The Plan Pays</b>		<b>The Plan Pays</b>		<b>The Plan Pays</b>	
100% coverage; after a \$100 copay per day max \$300 per admission	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible + \$50 copay per day (days 1-5)	100% coverage; after a \$100 copay per day max \$300 per admission	No Coverage
100% coverage; after a \$25 copay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a \$25 copay per visit	No Coverage
<b>The Plan Pays</b>		<b>The Plan Pays</b>		<b>The Plan Pays</b>	
100% coverage; after a \$25 copay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a \$25 copay per visit	No Coverage
100% coverage; after a \$25 copay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a \$25 copay per visit	No Coverage
80% coverage; subject to deductible	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	80% coverage; subject to deductible	No Coverage
No Coverage	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage
No Coverage	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage
100% coverage after a \$50 copay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a \$50 copay per visit	No Coverage
100% coverage subject to deductible	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage subject to deductible	No Coverage

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	Pelican HRA1000		Pelican HSA775	
	Network	Out-of-Network	Network	Out-of-Network
Other Coverage	The Plan Pays		The Plan Pays	
<b>Skilled Nursing Facility Services</b>	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Hospice Care</b>	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Durable Medical Equipment (DME) - Rental or Purchase</b>	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Transplant Services</b>	80% coverage; subject to deductible	No Coverage	80% coverage; subject to deductible	No Coverage
Pharmacy	You Pay		You Pay	
Tier 1 - Generic	50% up to \$30 <sup>1</sup>		\$10; subject to deductible <sup>1</sup>	
Tier 2 - Preferred	50% up to \$55 <sup>1,2</sup>		\$25; subject to deductible <sup>1</sup>	
Tier 3 - Non-Preferred	65% up to \$80 <sup>1,2</sup>		\$50; subject to deductible <sup>1</sup>	
Tier 4 - Specialty	50% up to \$80 <sup>1,2</sup>		\$50; subject to deductible <sup>1</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 copay		Applicable copay; Maintenance drugs not subject to deductible**	
<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 copay <sup>1</sup>		N/A	
Tier 2 - Preferred	\$20 copay <sup>1,2</sup>		N/A	
Tier 3 - Non-Preferred	\$40 copay <sup>1,2</sup>		N/A	
Tier 4 - Specialty	\$40 copay <sup>1,2</sup>		N/A	

**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.

\*\* For a complete list of maintenance medications visit: <https://www.bcbsla.com/ogb/pelican-hsa-775-active-employees>

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Magnolia Local Plus		Magnolia Open Access		Magnolia Local	
Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
The Plan Pays		The Plan Pays		The Plan Pays	
100% coverage; after a \$100 copay per day max \$300 per admission	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a \$100 copay per day max \$300 per admission	No Coverage
100% coverage; subject to deductible	No Coverage	80% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; subject to deductible	No Coverage
80% coverage of the first \$5,000 allowable; subject to deductible; 100% in excess of \$5,000 per plan year	No Coverage	90% coverage; subject to deductible	70% 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
100% coverage; not subject to deductible	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; subject to deductible	No Coverage
You Pay		You Pay		You Pay	
50% up to \$30 <sup>1</sup>		50% up to \$30 <sup>1</sup>		50% up to \$30 <sup>1</sup>	
50% up to \$55 <sup>1,2</sup>		50% up to \$55 <sup>1,2</sup>		50% up to \$55 <sup>1,2</sup>	
65% up to \$80 <sup>1,2</sup>		65% up to \$80 <sup>1,2</sup>		65% up to \$80 <sup>1,2</sup>	
50% up to \$80 <sup>1,2</sup>		50% up to \$80 <sup>1,2</sup>		50% up to \$80 <sup>1,2</sup>	
2.5 the cost of applicable maximum copay		2.5 the cost of applicable maximum copay		2.5 times the cost of applicable maximum copay	
After the out-of-pocket threshold amount of \$1,500 is met by you and/or your covered dependent(s) <sup>4</sup> :					
\$0 copay <sup>1</sup>				\$0 copay <sup>1</sup>	
\$20 copay <sup>1,2</sup>				\$20 copay <sup>1,2</sup>	
\$40 copay <sup>1,2</sup>				\$40 copay <sup>1,2</sup>	
\$40 copay <sup>1,2</sup>				\$40 copay <sup>1,2</sup>	

<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