Active Employees and Non-Medicare Retirees
(RETIREMENT DATE ON or AFTER March 1, 2015)
Benefits Comparison
Benefits effective January 1, 2018 - December 31, 2018

	Pelican HRA1000		Pelican HSA775		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		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		Active Employees & Non-Medicare Retirees (retirement date on or after AFTER 3-1-2015)	
	Network	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
	You Pay		**You Pay**		**You Pay**	
Deductible						
You	$2,000	$4,000	$2,000	$4,000	$400	No Coverage
You + 1 (Spouse or child)	$4,000	$8,000	$4,000	$8,000	$800	No Coverage
You + Children	$4,000	$8,000	$4,000	$8,000	$1,200	No Coverage
You + Family	$4,000	$8,000	$4,000	$8,000	$1,200	No Coverage
	HRA dollars will reduce this amount		HSA dollars will reduce this amount			
Out-of-Pocket Maximum						
You	$5,000	$10,000	$5,000	$10,000	$3,500	No Coverage
You + 1 (Spouse or child)	$10,000	$20,000	$10,000	$20,000	$6,000	No Coverage
You + Children	$10,000	$20,000	$10,000	$20,000	$8,500	No Coverage
You + Family	$10,000	$20,000	$10,000	$20,000	$8,500	No Coverage
State Funding	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
You	$1,000		$775*		Not Available	
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[5]			
Physicians' Services	**The Plan Pays**		**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	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after a $25 PCP or $50 SPC copayment per visit	No Coverage

Active Employees and Non-Medicare Retirees
(RETIREMENT DATE ON or AFTER 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	
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	**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**	
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

Active Employees and Non-Medicare Retirees
(RETIREMENT DATE ON or AFTER March 1, 2015)
Benefits Comparison
Benefits effective January 1, 2018 - December 31, 2018

	Pelican HRA1000		Pelican HSA775		Magnolia Local Plus	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
Physicians' Services	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Maternity Care (prenatal, delivery and postpartum)	80% coverage; subject to deductible	60% coverage; subject to deductible	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	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	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	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	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	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	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**		**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	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; after a $100 copayment per day max $300 per admission	No Coverage

Active Employees and Non-Medicare Retirees
(RETIREMENT DATE ON or AFTER 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; 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	70% 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
90% coverage; subject to deductible	90% 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
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% after deductible	No Coverage	80% coverage; subject to In-Network deductible	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; 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**	
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; not subject to deductible	50% coverage; subject to Out-of-Network Deductible

Active Employees and Non-Medicare Retirees
(RETIREMENT DATE ON or AFTER March 1, 2015)
Benefits Comparison
Benefits effective January 1, 2018 - December 31, 2018

	Pelican HRA1000		Pelican HSA775		Magnolia Local Plus	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
Hospital Services	The Plan Pays		The Plan Pays		The Plan Pays	
Outpatient Surgery/ Services Hospital / Facility	80% coverage; subject to deductible	60% coverage; subject to deductible	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	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		The Plan Pays	
Mental Health and Substance Abuse Inpatient Facility	80% coverage; subject to deductible	60% coverage; subject to deductible	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	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		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	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	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	80% coverage; subject to deductible	No Coverage
Vision Exam (routine)	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage
Urgent Care Center	80% coverage; subject to deductible	60% coverage; subject to deductible	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	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage subject to deductible	No Coverage

Active Employees and Non-Medicare Retirees
(RETIREMENT DATE ON or AFTER 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; not subject to deductible	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 $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; not subject to deductible	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; 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 $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 subject to deductible	No Coverage	100% coverage; subject to In-Network deductible	No Coverage

Active Employees and Non-Medicare Retirees
(RETIREMENT DATE ON or AFTER March 1, 2015)
Benefits Comparison
Benefits effective January 1, 2018 - December 31, 2018

	Pelican HRA1000		Pelican HSA775		Magnolia Local Plus	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
Other Coverage	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Skilled Nursing Facility Services	80% coverage; subject to deductible	60% coverage; subject to deductible	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	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; 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	80% coverage; subject to deductible	No Coverage	100% coverage; subject to deductible	No Coverage
Pharmacy	**You Pay**		**You Pay**		**You Pay**	
Tier 1 - Generic	50% up to $30 [1]		$10; subject to deductible [1]		50% up to $30 [1]	
Tier 2 - Preferred	50% up to $55 [1,2]		$25; subject to deductible [1]		50% up to $55 [1,2]	
Tier 3 - Non-Preferred	65% up to $80 [1,2]		$50; subject to deductible [1]		65% up to $80 [1,2]	
Tier 4 - Specialty	50% up to $80 [1,2]		$50; subject to deductible [1]		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		Applicable copayment; Maintenance drugs not subject to deductible**		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]		N/A		$0 copayment [1]	
Tier 2 - Preferred	$20 copayment [1,2]		N/A		$20 copayment [1,2]	
Tier 3 - Non-Preferred	$40 copayment [1,2]		N/A		$40 copayment [1,2]	
Tier 4 - Specialty	$40 copayment [1,2]		N/A		$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.
** For a complete list of maintenance medications visit www.bcbsla.com/state/pages/pharmacybenefits.aspx

Active Employees and Non-Medicare Retirees
(RETIREMENT DATE ON or AFTER 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 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
80% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; subject to deductible	No Coverage	100% coverage; subject to In-Network deductible	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	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
90% coverage; subject to deductible	70% 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 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 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)[4]:					
$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
[4] $1,500 threshold does not apply to Vantage Medical Home HMO pharmacy benefits