

## Active Employees and Non-Medicare Retirees

**(RETIREMENT DATE ON or AFTER March 1, 2015)**

### Benefits Comparison

**Benefits effective January 1, 2017 - December 31, 2017**

	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	
<b>Deductible</b>						
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			
<b>Out-of-Pocket Maximum</b>						
You	\$5,000	\$10,000	\$5,000	\$10,000	\$2,500	No Coverage
You + 1 (Spouse or child)	\$10,000	\$20,000	\$10,000	\$20,000	\$5,000	No Coverage
You + Children	\$10,000	\$20,000	\$10,000	\$20,000	\$7,500	No Coverage
You + Family	\$10,000	\$20,000	\$10,000	\$20,000	\$7,500	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 <sup>5</sup>			
Physicians' Services	The Plan Pays		The Plan Pays		The Plan Pays	
<b>Primary Care Physician or Specialist Office</b> - 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

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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		Tier I (Affinity Health Network "AHN" and standard) 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					
\$2,500	\$3,700	\$2,500	No Coverage	\$2,500	No Maximum
\$5,000	\$7,500	\$5,000	No Coverage	\$5,000	No Maximum
\$7,500	\$11,250	\$7,500	No Coverage	\$7,500	No Maximum
\$7,500	\$11,250	\$7,500	No Coverage	\$7,500	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

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	Pelican HRA1000		Pelican HSA775		Magnolia Local Plus	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
<b>Physicians' Services</b>	<b>The Plan Pays</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	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	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; subject to deductible	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; <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	No Coverage
<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	100% coverage; subject to deductible	100% coverage; subject to deductible
<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	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
<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	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	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; subject to deductible	No Coverage
<b>Hospital Services</b>	<b>The Plan Pays</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	100% coverage; after a \$100 copayment per day max \$300 per admission	No Coverage

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**Benefits Comparison**

**Benefits effective January 1, 2017 - December 31, 2017**

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>	
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 Tier I deductible	50% coverage; subject to Out-of-Network Deductible
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; <b>not</b> 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 Tier I 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 Tier I 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 Tier I deductible	50% coverage; subject to Out-of-Network Deductible
<b>The Plan Pays</b>		<b>The Plan Pays</b>		<b>The Plan Pays</b>	
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**

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**Benefits Comparison**

**Benefits effective January 1, 2017 - December 31, 2017**

	Pelican HRA1000		Pelican HSA775		Magnolia Local Plus	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
<b>Hospital Services</b>	<b>The Plan Pays</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	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	80% coverage; subject to deductible	80% coverage; subject to deductible	100% coverage after \$150 copayment per visit; waived if admitted	100% coverage after \$150 copayment per visit; waived if admitted
<b>Behavioral Health</b>	<b>The Plan Pays</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	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	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>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	100% coverage; after a \$25 copayment per visit	No Coverage
<b>Chiropractic Care</b>	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
<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	80% coverage; subject to deductible	No Coverage
<b>Vision Exam (routine)</b>	No Coverage	No Coverage	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	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	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
<b>The Plan Pays</b>		<b>The Plan Pays</b>		<b>The Plan Pays</b>	
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 \$150 copayment per visit; waived if admitted	100% coverage after \$150 copayment per visit; not subject to deductible
<b>The Plan Pays</b>		<b>The Plan Pays</b>		<b>The Plan Pays</b>	
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
<b>The Plan Pays</b>		<b>The Plan Pays</b>		<b>The Plan Pays</b>	
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 Tier I 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 Tier I deductible	No Coverage

**Active Employees and Non-Medicare Retirees  
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	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	
<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	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	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; subject to deductible	No Coverage
<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	80% coverage of the first \$5,000 allowable; subject to deductible; 100% in excess of \$5,000 per plan year	No Coverage
<b>Transplant Services</b>	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 <sup>1</sup>		\$10; subject to deductible <sup>1</sup>		50% up to \$30 <sup>1</sup>	
Tier 2 - Preferred	50% up to \$55 <sup>1,2</sup>		\$25; subject to deductible <sup>1</sup>		50% up to \$55 <sup>1,2</sup>	
Tier 3 - Non-Preferred	65% up to \$80 <sup>1,2</sup>		\$50; subject to deductible <sup>1</sup>		65% up to \$80 <sup>1,2</sup>	
Tier 4 - Specialty	50% up to \$80 <sup>1,2</sup>		\$50; subject to deductible <sup>1</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		Applicable copayment; Maintenance drugs not subject to deductible**		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>		N/A		\$0 copayment <sup>1</sup>	
Tier 2 - Preferred	\$20 copayment <sup>1,2</sup>		N/A		\$20 copayment <sup>1,2</sup>	
Tier 3 - Non-Preferred	\$40 copayment <sup>1,2</sup>		N/A		\$40 copayment <sup>1,2</sup>	
Tier 4 - Specialty	\$40 copayment <sup>1,2</sup>		N/A		\$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.

\*\* For a complete list of maintenance medications visit [www.bcbsla.com/state/pages/pharmacybenefits.aspx](http://www.bcbsla.com/state/pages/pharmacybenefits.aspx)

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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	
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 Tier I 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 Tier I 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 Tier I deductible	No Coverage
You Pay		You Pay		You Pay	
50% up to \$30 <sup>1</sup>		50% up to \$30 <sup>1</sup>		Tier 1 - Preferred Generics Tier 2 - Non-Preferred Generics	\$5 copayment <sup>3</sup> \$20 copayment <sup>3</sup>
50% up to \$55 <sup>1,2</sup>		50% up to \$55 <sup>1,2</sup>		Tier 3 - Preferred Brand	\$50 copayment <sup>2,3</sup>
65% up to \$80 <sup>1,2</sup>		65% up to \$80 <sup>1,2</sup>		Tier 4 - Non-Preferred Brand	\$80 copayment <sup>2,3</sup>
50% up to \$80 <sup>1,2</sup>		50% up to \$80 <sup>1,2</sup>		Tier 5 - Specialty	\$150 copayment <sup>2,3</sup>
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) <sup>4</sup> :					
\$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

<sup>4</sup>\$1,500 threshold does not apply to Vantage Medical Home HMO pharmacy benefits <sup>5</sup> HSA775 employer contribution and match not applicable to COBRA