Active Employees and Non-Medicare Retirees
(RETIREMENT DATE ON or AFTER March 1, 2015)
Benefits Comparison
Benefits effective January 1, 2021 - December 31, 2021

	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	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-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 copay per visit	No Coverage

Active Employees and Non-Medicare Retirees
(RETIREMENT DATE ON or AFTER March 1, 2015)
Benefits Comparison
Benefits effective January 1, 2021 - December 31, 2021

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	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**
You Pay		**You Pay**		**You Pay**	
Deductible					
$900	$900	$400	No Coverage	$400	$2,000
$1,800	$1,800	$800	No Coverage	$800	$4,000
$2,700	$2,700	$1,200	No Coverage	$1,200	$6,000
$2,700	$2,700	$1,200	No Coverage	$1,200	$6,000
Out-of-Pocket Maximum					
$3,500	$4,700	$2,500	No Coverage	$3,500	$5,000 Benefit Maximum
$6,000	$8,500	$5,000	No Coverage	$6,000	$15,000 Benefit Maximum
$8,500	$12,250	$7,500	No Coverage	$8,500	$15,000 Benefit Maximum
$8,500	$12,250	$7,500	No Coverage	$8,500	$15,000 Benefit 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 copay per visit	No Coverage	100% coverage after a $10 AHN/$25 PCP or $35 AHN/$50 SPC copay 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, 2021 - December 31, 2021						
	Pelican HRA1000		Pelican HSA775		Magnolia Local Plus	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-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 copay 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 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	100% coverage after a $25 PCP or $50 SPC per office visit copay 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 copay 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 copay 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, 2021 - December 31, 2021

Magnolia Open Access		Magnolia Local		Vantage Medical Home HMO	
Network	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-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 copay per pregnancy	No Coverage	100% coverage after a $10 AHN/$25 copay 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 In-Network deductible	50% coverage; not 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; subject to In-Network deductible	100% coverage; subject to In- Network deductible
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	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 copay per visit	No Coverage	100% coverage after a $10 AHN/$25 PCP or $35 AHN/$50 SPC office visit copay 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 copay per day (days 1 - 5)	100% coverage; after a $100 copay per day max $300 per admission	No Coverage	100% coverage after a $50 AHN/$100 copay 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, 2021 - December 31, 2021

	Pelican HRA1000		Pelican HSA775		Magnolia Local Plus	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-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 copay 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 copay per visit; waived if admitted	100% coverage after $200 copay 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 copay 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 copay 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 copay 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 copay 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) and Eye Wear	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage	No Coverage
Comprehensive Dental	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 copay 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, 2021 - December 31, 2021

Magnolia Open Access		Magnolia Local		Vantage Medical Home HMO	
Network	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-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 copay per visit	No Coverage	100% coverage after a $50 AHN/$100 copay; not subject to deductible	50% coverage; subject to Out-of-Network Deductible
90% coverage; subject to deductible; $150 copay per visit; waived if admitted	90% coverage; subject to deductible; $150 copay per visit; waived if admitted	100% coverage after $150 copay per visit; waived if admitted	100% coverage after $150 copay per visit; waived if admitted	100% coverage after a $200 copay per visit; waived if admitted	100% coverage after $200 copay per visit; waived if admitted
The Plan Pays		**The Plan Pays**		**The Plan Pays**	
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 $50 AHN/$100 copay 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 copay per visit	No Coverage	100% coverage after a $10 AHN/$25 PCP copay 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 copay per visit	No Coverage	100% coverage after a $10 AHN/$25 copay 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 copay per visit	No Coverage	100% coverage after a $25 PCP copay 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	Exam: $35 AHN/$50 copay per visit; Eye-wear: 50% coinsurance, with a $100 benefit max for all members; not subject to deductible	Exam: 50% coverage; subject to Out-of-Network Deductible; Eye-wear: 50% coinsurance, with a $100 benefit max for all members; not subject to deductible
No Coverage	No Coverage	No Coverage	No Coverage	Preventive: 100% coverage, not subject to deductible; Basic/Major: 50% coinsurance, with a $500 benefit max for all members; not subject to deductible	Preventive: 100% coverage, not subject to deductible; Basic/Major: 50% coinsurance, with a $500 benefit max for all members; not subject to deductible
90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a $50 copay per visit	No Coverage	100% coverage; after a $50 copay 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
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Benefits Comparison
Benefits effective January 1, 2021 - December 31, 2021

	Pelican HRA1000		Pelican HSA775		Magnolia Local Plus	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-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 copay 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; not 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 copay		Applicable copay; Maintenance drugs not subject to deductible**		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):						
Tier 1 - Generic	$0 copay [1]		N/A		$0 copay [1]	
Tier 2 - Preferred	$20 copay [1,2]		N/A		$20 copay [1,2]	
Tier 3 - Non-Preferred	$40 copay [1,2]		N/A		$40 copay [1,2]	
Tier 4 - Specialty	$40 copay [1,2]		N/A		$40 copay [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, 2021 - December 31, 2021

Magnolia Open Access		Magnolia Local		Vantage Medical Home HMO	
Network	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-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 copay per day max $300 per admission	No Coverage	100% coverage after $100 copay 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 copay per day, max $300 per admission; not 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: $0 AHN/$10 copay[3] Tier 2 - Non-Preferred Generics: $40 copay[3]	
50% up to $55 [1,2]		50% up to $55 [1,2]		Tier 3 - Preferred Brand: $65 copay[2,3]	
65% up to $80 [1,2]		65% up to $80 [1,2]		Tier 4 - Non-Preferred Brand: $100 copay[2,3]	
50% up to $80 [1,2]		50% up to $80 [1,2]		Tier 5 - Specialty: $150 copay[2,3]	
2.5 the cost of applicable maximum copay		2.5 times the cost of applicable maximum copay		Tier I Preferred Generics: $0 AHN copay; Tiers 1-4: 3 copays; Tier 5 Specialty: 100-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 copay [1]		$0 copay [1]		N/A	
$20 copay [1,2]		$20 copay [1,2]		N/A	
$40 copay [1,2]		$40 copay [1,2]		N/A	
$40 copay [1,2]		$40 copay [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