| Retirees with Medicare<br>(RETIREMENT DATE BEFORE March 1, 2015)<br>Benefits Comparison<br>Benefits effective January 1, 2021 - December 31, 2021 | | | | |
|---|---|---|---|---|
| | **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 BEFORE 3/1/2015) | | Medicare Retirees (retirement date BEFORE 3/1/2015) | |
| | **Network** | **Out-of-Network** | **Network** | **Out-of-Network** |
| | **You Pay** | | **You Pay** | |
| | **Deductible** | | | |
| You | $2,000 | $4,000 | $0 | No Coverage |
| You + 1 (Spouse or child) | $4,000 | $8,000 | $0 | |
| You + Children | $4,000 | $8,000 | $0 | |
| You + Family | $4,000 | $8,000 | $0 | |
| | HRA dollars will reduce this amount | | | |
| | **Out-of-Pocket Maximum** | | | |
| You | $5,000 | $10,000 | $2,000 | No Coverage |
| You + 1 (Spouse or child) | $10,000 | $20,000 | $3,000 | |
| You + Children | $10,000 | $20,000 | $4,000 | |
| You + Family | $10,000 | $20,000 | $4,000 | |
| **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 copay per visit | No Coverage |

## Retirees with Medicare
## (RETIREMENT DATE BEFORE 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 | |
| Medicare Retirees (retirement date BEFORE 3/1/2015) | | Medicare Retirees (retirement date BEFORE 3/1/2015) | | Medicare Retirees (retirement date BEFORE 3/1/2015) | |
| **Network** | **Out-of-Network** | **Network** | **Out-of-Network** | **Network** | **Out-of-Network** |
| **You Pay** | | **You Pay** | | **You Pay** | |
| **Deductible** | | | | | |
| $300 | | $0 | No Coverage | $0 | $2,000 |
| $600 | | $0 | | $0 | $4,000 |
| $900 | | $0 | | $0 | $6,000 |
| $900 | | $0 | | $0 | $6,000 |
| | | | | | |
| **Out-of-Pocket Maximum** | | | | | |
| $3,300 individual; plus $2,300 per additional person up to 2; plus $2,000 per additional person up to 2 additional people; $13,700 for a family of 5+ | | $1,000 | No Coverage | $2,000 | $5,000 Benefit Maximum |
| | | $2,000 | | $3,000 | $15,000 Benefit Maximum |
| | | $3,000 | | $4,000 | $15,000 Benefit Maximum |
| | | $3,000 | | $4,000 | $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** | |
| 80% coverage; subject to deductible | 80% 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 |

## Retirees with Medicare
## (RETIREMENT DATE BEFORE March 1, 2015)
## Benefits Comparison
## Benefits effective January 1, 2021 - December 31, 2021

| | Pelican HRA1000 | | Magnolia Local Plus | |
|---|---|---|---|---|
| | **Network** | **Out-of-Network** | **Network** | **Out-of-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 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 | 100% coverage | 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 | No Coverage |
| **Physician Services for Emergency Room Care** | 80% coverage; subject to deductible | 80% coverage; subject to deductible | 100% coverage | 100% coverage |
| **Allergy Shots and Serum** Copay 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 copay per visit; shots and serum 100% | 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 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 | 100% coverage | 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 copay per day max $300 per admission | No Coverage |

## Retirees with Medicare
## (RETIREMENT DATE BEFORE 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** | |
| 80% coverage; subject to deductible | 80% 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 |
| 80% coverage; subject to deductible | 80% coverage; subject to deductible | 100% coverage | No Coverage | 100% coverage | 50% coverage; subject to Out-of-Network Deductible |
| 100% coverage; **not** subject to deductible | 80% coverage; subject to deductible | 100% coverage | No Coverage | 100% coverage | 50% coverage; not subject to Out-of-Network deductible |
| 80% coverage; subject to deductible | 80% coverage; subject to deductible | 100% coverage | 100% coverage | 100% coverage | 100% coverage |
| 80% coverage; subject to deductible | 80% coverage; subject to deductible | 100% coverage after a $25 PCP or $50 SPC per office visit copay per visit; shots and serum 100% | No Coverage | 80% coverage | 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 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 |
| 80% coverage; subject to deductible | 80% coverage; subject to deductible | 100% coverage | No Coverage | 100% coverage | 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 $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 | 50% coverage; subject to Out-of-Network Deductible |

| Retirees with Medicare<br>(RETIREMENT DATE BEFORE March 1, 2015)<br>Benefits Comparison<br>Benefits effective January 1, 2021 - December 31, 2021 | | | | |
|---|---|---|---|---|
| | Pelican HRA1000 | | Magnolia Local Plus | |
| | Network | Out-of-Network | Network | Out-of-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 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 | 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 | |
| **Mental Health and Substance Abuse** Inpatient Facility | 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 | 100% coverage; after a $25 copay 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 copay per visit | No Coverage |
| **Chiropractic Care** | 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 | No Coverage |
| **Vision Exam (routine) and Eye Wear** | No Coverage | No Coverage | No Coverage | No Coverage |
| **Comprehensive Dental** | 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 copay per visit | No Coverage |
| **Home Health Care Services** | 80% coverage; subject to deductible | 60% coverage; subject to deductible | 100% coverage | No Coverage |

## Retirees with Medicare
## (RETIREMENT DATE BEFORE 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** | |
| 80% coverage; subject to deductible | 80% coverage; subject to deductible | 100% coverage; after a $100 facility copay per visit | No Coverage | 100% coverage after a $50 AHN/$100 copay | 50% coverage; subject to Out-of-Network Deductible |
| 80% coverage; subject to deductible; $150 copay per visit; waived if admitted | 80% 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 a $200 copay per visit; waived if admitted |
| **The Plan Pays** | | **The Plan Pays** | | **The Plan Pays** | |
| 80% coverage; subject to deductible | 80% coverage; subject to deductible | 100% coverage; after a $100 copay per day max $300 per admission | No Coverage | 100% coverage after a $100 copay per day; max $300 per admission | 50% coverage; subject to Out-of-Network Deductible |
| 80% coverage; subject to deductible | 80% 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 |
| **The Plan Pays** | | **The Plan Pays** | | **The Plan Pays** | |
| 80% coverage; subject to deductible | 80% 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 |
| 80% coverage; subject to deductible | 80% 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 |
| 80% coverage; subject to deductible | 80% coverage; subject to deductible | 80% coverage | No Coverage | 80% coverage | 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 | 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; Basic/Major: 50% coinsurance, with a $500 benefit max for all members | Preventive: 100% coverage, not subject to deductible; Basic/Major: 50% coinsurance, with a $500 benefit max for all members; not subject to deductible |
| 80% coverage; subject to deductible | 80% 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 |
| No Coverage | No Coverage | 100% coverage | No Coverage | 100% coverage | No Coverage |

## Retirees with Medicare
## (RETIREMENT DATE BEFORE March 1, 2015)
## Benefits Comparison
## Benefits effective January 1, 2021 - December 31, 2021

| | Pelican HRA1000 | | Magnolia Local Plus | |
|---|---|---|---|---|
| | Network | Out-of-Network | Network | Out-of-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 copay per day max $300 per admission | No Coverage |
| **Hospice Care** | 80% coverage; subject to deductible | 60% coverage; subject to deductible | 100% coverage | 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; 100% in excess of $5,000 per plan year; | No Coverage |
| **Transplant Services** | 80% coverage; subject to deductible | No Coverage | 100% coverage | 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 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):** | | | | |
| Tier 1 - Generic | $0 copay [1] | | $0 copay [1] | |
| Tier 2 - Preferred | $20 copay [1,2] | | $20 copay [1,2] | |
| Tier 3 - Non-Preferred | $40 copay [1,2] | | $40 copay [1,2] | |
| Tier 4 - Specialty | $40 copay [1,2] | | $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.

## Retirees with Medicare
## (RETIREMENT DATE BEFORE 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** | |
| 80% coverage; subject to deductible | 80% 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 | 50% coverage; subject to Out-of-Network Deductible |
| No Coverage | No Coverage | 100% coverage | No Coverage | 100% coverage | No Coverage |
| 80% coverage; subject to deductible | 80% coverage; subject to deductible | 80% coverage of the first $5,000 allowable; 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 | 50% coverage; subject to Out-of-Network deductible |
| 80% coverage; subject to deductible | 80% coverage; subject to deductible | 100% coverage | No Coverage | 100% coverage after $100 copay per day, max $300 per admission | 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]<br>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 times 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)*:** | | | | | |
| $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
* $1,500 threshold does not apply to Vantage Medical Home HMO pharmacy benefits