

Retirees(before March 1, 2015) without Medicare Benefits Comparison: Pelican HRA1000, Magnolia Local, Magnolia Local Plus, Magnolia Open Access, Vantage Medical Home				
Blue Cross Blue Shield benefits effective March 1, 2015 - December 31, 2015				
Vantage Medical Home benefits effective January 1, 2015 - December 31, 2015				
	Pelican HRA 1000		Magnolia Local	
Network	Blue Cross Blue Shield of Louisiana Preferred Care Providers & BCBS National Providers		Blue Cross Blue Shield of Louisiana Community Blue & Blue Connect	
Eligible OGB Members	Retirees without Medicare		Retirees without Medicare	
	Network	Non-Network	Network	Non-Network
	You Pay		You Pay	
	Deductible			
You	\$2,000	\$4,000	\$0	No Coverage
You + Spouse	\$4,000	\$8,000	\$0	
You + Child(ren)	\$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	\$1,000	No Coverage
You + Spouse	\$10,000	\$20,000	\$2,000	
You + Child(ren)	\$10,000	\$20,000	\$3,000	
You + Family	\$10,000	\$20,000	\$3,000	
	The Plan Pays		The Plan Pays	
You	\$1,000		Not Available	
You + Spouse	\$2,000			
You + Child(ren)	\$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 <i>Treatment of illness or injury</i>	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after a \$25 PCP or \$50 SPC co-payment per visit	No coverage
Maternity Care <i>Prenatal, delivery and postpartum</i>	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after a \$90 co-payment per pregnancy	No coverage
Physician Services Furnished in a Hospital <i>Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist</i>	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage	No coverage
Preventative Care Primary Care Physician or Specialist Office or Clinic <i>For a complete list of benefits, refer to the Preventive and Wellness/Routine Care in the Benefit Plan</i>	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	100% coverage	No coverage
Physician Services for Emergency Room Care	80% coverage; subject to deductible	80% coverage; subject to deductible	100% coverage	100% coverage

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Vantage Medical Home benefits effective January 1, 2015 - December 31, 2015						
	Magnolia Local Plus		Magnolia Open Access		Vantage Medical Home	
Network	Blue Cross Blue Shield of Louisiana Preferred Care Providers & BCBS National Providers		Blue Cross Blue Shield of Louisiana Preferred Care Providers & BCBS National Providers		Statewide HMO plan offered in all regions of Louisiana	
Eligible OGB Members	Retirees without Medicare		Retirees without Medicare		Retirees without Medicare	
	Network	Non-Network	Network	Non-Network	Network	
	You Pay		You Pay		You Pay	
	Deductible					
	\$0	No coverage	\$300	\$500	\$1,500	
	\$0		\$600	\$1,500	\$3,000	
	\$0		\$900	\$1,500	\$3,000	
	\$0		\$900	\$1,500	\$3,000	
	Out-of-Pocket Maximum					
	\$1,000	No coverage	\$1,300 individual; plus \$1,300 per additional person up to 2; plus \$1,000 per additional person up to 10 people; \$12,700 for a family of 12+	\$3,300 individual; plus \$3,300 per additional person up to 2; \$12,700 for a family of 4+	\$3,000	Unlimited
	\$2,000				\$9,000	
	\$3,000				\$9,000	
	\$3,000				\$9,000	
	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 co-payment per visit	No coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a \$0*/\$10 PCP or \$35*/\$45 SPC co-payment per visit	
	100% coverage after a \$90 co-payment per pregnancy	No coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a \$0*/\$10 co-payment per pregnancy	
	100% coverage	No coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; subject to deductible	
	100% coverage	No coverage	90% coverage; not subject to deductible	70% coverage; subject to deductible	100% coverage; not subject to deductible	
	100% coverage	100% coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; subject to deductible	

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	Pelican HRA 1000		Magnolia Local	
	Network	Non-Network	Network	Non-Network
Physicians' Services	The Plan Pays		The Plan Pays	
Maternity Care (prenatal, deliver and postpartum)	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after a \$90 co-payment 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	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 Co-payment 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 co-payment 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 co-payment 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 co-payment per day max \$300 per admission	No Coverage

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	Magnolia Local Plus		Magnolia Open Access		Vantage Medical Home	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
	The Plan Pays		The Plan Pays		The Plan Pays	
	100% coverage; after a \$90 co-payment per pregnancy	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a \$0*/\$10 co-payment per pregnancy	50% coverage; subject to deductible
	100% coverage;	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; subject to deductible	50% coverage; subject to deductible
	100% coverage	No Coverage	100% coverage; not subject to deductible	70% coverage; subject to deductible	100% coverage; not subject to deductible	50% coverage; subject to deductible
	100% coverage	100% coverage	90% coverage; subject to deductible	90% coverage; subject to deductible	100% coverage; subject to deductible	50% coverage; subject to deductible
	100% coverage after a \$25 PCP or \$50 SPC per office visit co-payment per visit; shots and serum 100%	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	80% coverage; subject to deductible	50% coverage; subject to deductible
	100% coverage after a \$25 PCP or \$50 SPC per office visit co-payment per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; subject to deductible	50% coverage; subject to deductible
	100% coverage	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; subject to deductible	50% coverage; subject to deductible
	The Plan Pays		The Plan Pays		The Plan Pays	
	100% coverage; after a \$100 co-payment per day max \$300 per admission	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible + \$50 co-payment per day (days 1 - 5)	100% coverage after a \$100*/\$300 co-payment per day max \$300*/\$900 per admission; subject to deductible	50% coverage; subject to deductible

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	Network	Non-Network	Network	Non-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 co-payment per visit	No Coverage
Emergency Room Care - Hospital Treatment of an emergency medical condition or injury	80% coverage; subject to deductible	80% coverage; subject to deductible	100% coverage after \$150 co-payment per visit; waived if admitted	100% coverage after \$150 co-payment 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 co-payment 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 co-payment 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 co-payment per visit	No Coverage
Chiropractic Care	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; after a \$25 co-payment 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)	No Coverage			
Urgent Care Center	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; after a \$50 co-payment per visit	No Coverage
Home Health Care Services	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage	No Coverage

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	Network	Non-Network	Network	Non-Network	Network	Non-Network
	The Plan Pays		The Plan Pays		The Plan Pays	
100% coverage; after a \$100 facility co-payment per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a \$100*/\$300 co-payment per visit; subject to deductible	50% coverage; subject to deductible	
100% coverage after \$150 co-payment per visit; waived if admitted	100% coverage after \$150 co-payment per visit; waived if admitted	\$150 co-payment per visit; waived if admitted		100% coverage after a \$200 co-payment per visit; subject to deductible	100% coverage after a \$200 co-payment per visit; subject to deductible	
	The Plan Pays		The Plan Pays		The Plan Pays	
100% coverage after \$100 co-payment per day max \$300 per admission	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible + \$50 co-payment per day (days 1-5)	100% coverage; after a \$300 co-payment per day max \$900 per admission; subject to deductible	50% coverage; subject to deductible	
100% coverage; after a \$25 co-payment per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a \$10 PCP or \$45 SPC per co-payment per visit	50% coverage; subject to deductible	
	The Plan Pays		The Plan Pays		The Plan Pays	
100% coverage; after a \$25 co-payment per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	80% coverage; subject to deductible	50% coverage; subject to deductible	
100% coverage; after a \$25 co-payment per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; after a \$10 co-payment per visit	50% coverage; subject to deductible	
80% coverage	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	80% coverage; subject to deductible	50% coverage; subject to deductible	
	No Coverage				100% coverage; after a \$45 co-payment per visit	50% coverage; subject to deductible
100% coverage after a \$50 co-payment per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a \$45 co-payment per visit	50% coverage; subject to deductible	
100% coverage	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	80% coverage; subject to deductible	50% coverage; subject to deductible	

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	Network	Non-Network	Network	Non-Network
Hospital Services	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 co-payment 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 supplies for maintenance drugs from mail order OR at participating 90-day retail network pharmacies	Two and a half times the cost of your applicable co-payment		Two and a half times the cost of your applicable co-payment	
After the out-of-pocket amount of \$1,500 is met:				
Tier 1 - Generic	\$0 co-payment ¹		\$0 co-payment ¹	
Tier 2 - Preferred	\$20 co-payment ^{1,2}		\$20 co-payment ^{1,2}	
Tier 3 - Non-Preferred	\$40 co-payment ^{1,2}		\$40 co-payment ^{1,2}	
Tier 4 - Specialty	\$40 co-payment ^{1,2}		\$40 co-payment ^{1,2}	

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	Network	Non-Network	Network	Non-Network	Network	Non-Network
Hospital Services	The Plan Pays		The Plan Pays		The Plan Pays	
100% coverage; after \$100 co-payment per day max \$300 per admission	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a \$50 co-payment per day	50% coverage; subject to deductible	
100% coverage	No Coverage	80% coverage; subject to deductible	70% coverage; subject to deductible	80% coverage; subject to deductible	50% coverage; subject to deductible	
80% coverage of the first \$5,000 allowable; 100% in excess of \$5,000 per plan year;	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	80% coverage; subject to deductible	50% coverage; subject to deductible	
100% coverage	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	80% coverage; subject to deductible	No Coverage	
Pharmacy	You Pay		You Pay		You Pay	
50% up to \$30 ¹	50% up to \$30 ¹		Low Cost Generics - \$3 co-payment ³ Non Preferred Generics - \$10 co-payment ³			
50% up to \$55 ^{1,2}	50% up to \$55 ^{1,2}		\$45 co-payment ³			
65% up to \$80 ^{1,2}	65% up to \$80 ^{1,2}		\$95 co-payment ³			
50% up to \$80 ^{1,2}	50% up to \$80 ^{1,2}		33% up to \$150 ³			
Two and a half times the cost of your applicable co-payment	Two and a half times the cost of your applicable co-payment		30-day supply for 1 co-pay; 60-day supply for 2 co-pays; 90-day supply for 3 co-pays – All tiers but Tier 5			
After the out-of-pocket amount of \$1,500 is met:						
\$0 co-payment ¹	\$0 co-payment ¹		-			
\$20 co-payment ^{1,2}	\$20 co-payment ^{1,2}		-			
\$40 co-payment ^{1,2}	\$40 co-payment ^{1,2}		-			
\$40 co-payment ^{1,2}	\$40 co-payment ^{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 full details of the plan, refer to the official plan document. Benefits outlined in the Vantage Medical Home column were provided by Vantage Health Plan. OGB is not responsible for the accuracy of this information.

¹Prescription drug benefit - 31 day fill; ²Member who chooses brand-name drug for which approved generic version is available pays cost difference between brand-name drug & generic drug, plus co-pay for brand-name drug; cost difference does not apply to \$1,500 out of pocket max; ³Prescription drug benefit - 30 day fill

*Benefits available for Affinity Health Network Providers