





ENROLLMENT GUIDE FOR PLAN YEAR 2027

for all members

ANNUAL ENROLLMENT | OCTOBER 1 – NOVEMBER 15, 2026

ogb.la.gov

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 91 for more details.

RESOURCES / CONTACT INFORMATION

If you have any questions about annual enrollment, visit **ogb.la.gov** or call us at 1-800-272-8451. You can also contact our vendors with specific questions at the phone numbers below.

OGB Customer Service Hours: 8:00 AM - 4:30 PM Monday - Friday	1-800-272-8451	ogb.la.gov
Vendor	**Customer Service**	**Website**
Louisiana Blue Hours: 8:00 AM - 5:00 PM CT Monday - Friday	1-800-392-4089	lablue.com/ogb
Health Equity Hours: 24 hours a day Seven days a week	1-866-346-5800	www.HealthEquity.com
Liviniti Hours: 24 hours a day Seven days a week	1-833-925-2770	https://microsite.liviniti.com/
SilverScript Hours: 24 hours a day Seven days a week	1-888-996-0104	www.caremark.com
Blue Advantage HMO Hours: 8:00 AM - 8:00 PM CT Seven days a week	1-866-508-7145 (TTY 711)	blueadvantage.bcbsla.com/groups/pine
Humana Hours: 7 a.m. – 7 p.m. CT Monday - Friday	1-877-889-9885 (TTY: 711)	www.Humana.com
Peoples Health 7 a.m. - 8 p.m. CST Seven days a week, Oct. to March; Monday through Friday, April to Sept.	1-866-877-5403 (TTY: 711)	peopleshealth.com
TASC Hours: 24 hours a day Seven days a week	1-844-237-9222	www.tasconline.com
Via Benefits Hours: 7:00 AM - 8:00 PM CT Monday - Friday	1-855-663-4228	my.ViaBenefits.com/ogb
Additional Information	**Member Services**	**Website**
Centers for Medicare & Medicaid (CMS) 24 Hours a day / 7 days a week	1-800-633-4227	www.medicare.gov
Social Security Administration	1-800-772-1213	www.ssa.gov

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Letter from the CEO

Dear OGB Members,

Annual Enrollment is your opportunity each year to review your benefits, consider your healthcare needs and make sure your coverage continues to work for you and your family.

We recognize that you are receiving your 2027 Annual Enrollment materials later than in previous years, and we sincerely apologize for the delay. Due to the procurement process for OGB's health plan contracts, OGB was required to observe a blackout period that limited our ability to communicate certain plan information until the contracts were approved. We appreciate your patience and understanding throughout this process.

Your 2027 Coverage

We are pleased to share that OGB will continue to offer our self-funded health plans through Louisiana Blue for 2027. We will also continue to offer three Medicare Advantage plan options through Blue Advantage, Humana and Peoples Health, along with access to the Medicare Marketplace Exchange through Via Benefits.

If you're satisfied with your current OGB health plan and covered dependents for 2027, no action is needed—your coverage will automatically continue into the new plan year. If you want to change your health plan, add or remove coverage, or explore your available options, Annual Enrollment is the time to make those changes.

This guide provides information about your 2027 benefit options, premiums and important updates for the year ahead.

Premium Update

Healthcare costs continue to increase across Louisiana and the nation. OGB understands the impact rising costs can have on you and your family and remains committed to carefully managing plan costs while providing quality benefits.

Beginning January 1, 2027, premiums for OGB's self-funded health plans will increase by 7.75%. The 2027 premium rates and plan information are included in this guide.

We're Here for You

We encourage you to review this guide and attend an Annual Enrollment meeting to learn more about your 2027 benefit options and ask questions before making your enrollment decisions. The full meeting schedule is included in this guide and will also be available online at ogb.la.gov.

We appreciate your patience with this year's delayed materials. The OGB team is committed to providing you with the information and support you need to make informed decisions about your healthcare coverage.

We look forward to continuing to serve you and your family in 2027.

Best regards,



Heath Williams
Chief Executive Officer
Office of Group Benefits

ACTIVE EMPLOYEE & REHIRED RETIREE MEETING SCHEDULE

Annual Enrollment is October 1 - November 15

Join us at any of the meetings listed below to get details about your options. **There are two classroom-style presentations per day, each lasting about two hours.**

LSU First benefits will not be discussed at these meetings. Please contact LSU for information regarding LSU First annual enrollment meetings.

Interpreter for hearing-impaired members is available upon request submitted 48 hours in advance. Contact Customer Service at 1-800-272-8451.

DATE	LOCATION	START TIMES
Sept. 22	**https://la-ogb.zoom.us/meeting/register/qNXrbDUmRxCzfwmV9Cu1iA**	9:00 AM
Sept. 22	**https://la-ogb.zoom.us/meeting/register/rv1XnQoWQWebXSQASUCnHw**	2:00 PM
Sept. 23	**https://la-ogb.zoom.us/meeting/register/BoEv2w0PRniOWl7Dr8hfbA**	9:00 AM
Sept. 23	**https://la-ogb.zoom.us/meeting/register/SHvu-N2cTbm26b_DZExxCQ**	2:00 PM

Visit ogb.la.gov or call 1-800-272-8451 for more information.

NON-MEDICARE RETIREE MEETINGS SCHEDULE

Annual Enrollment is October 1 - November 15

Join us at any of the meetings listed below to get details about your options. **There are two classroom style presentations per day, each lasting about two hours.**

LSU First benefits will not be discussed at these meetings. Please contact LSU for information regarding LSU First annual enrollment meetings.

Interpreter for hearing-impaired members is available upon request submitted 1 week in advance. Contact Customer Service at 1-800-272-8451.

DATE	LOCATION	START TIMES
September 30	State Police Headquarters Auditorium (BLDG. A) 7901 Independence Blvd., Baton Rouge, LA 70806	9:00 AM or 2:00 PM
September 30	Alexandria Convention Center 2225 N MacArthur Dr., Alexandria, LA 71303	9:00 AM or 2:00 PM
October 13	University of New Orleans (University Center Ballroom) 2000 Lakeshore Drive, New Orleans, LA 70148	9:00 AM or 2:00 PM
October 13	West Monroe Convention Center 901 Ridge Avenue, West Monroe, LA 71291	9:00 AM or 2:00 PM
October 21	Southeastern Louisiana University Alumni Welcome Center 500 W University Ave, Hammond, LA 70401	9:00 AM or 2:00 PM
October 27	Houma - Terrebonne Civic Center 346 Civic Center Blvd., Houma, LA 70360	9:00 AM or 2:00 PM
October 27	Bossier City Civic Center 620 Benton Road, Bossier City, LA 71111	9:00 AM or 2:00 PM
November 3	Lake Charles Civic Center - Contraband Room 900 Lakeshore Drive, Lake Charles, LA 70602	9:00 AM or 2:00 PM
November 11	University of Louisiana-Lafayette Cecil J. Picard Center 200 East Devalcourt Street, Lafayette, LA 70506	9:00 AM or 2:00 PM

Visit ogb.la.gov or call 1-800-272-8451 for more information.

MEDICARE RETIREE MEETINGS SCHEDULE

Annual Enrollment is October 1 - November 15

Join us at any of the meetings listed below to get details about your options. **There are two classroom style presentations per day, each lasting about two hours.**

LSU First benefits will not be discussed at these meetings. Please contact LSU for information regarding LSU First annual enrollment meetings.

Interpreter for hearing-impaired members is available upon request submitted 1 week in advance. Contact Customer Service at 1-800-272-8451.

DATE	LOCATION	START TIMES
October 1	State Police Training Academy Auditorium (BLDG. A) 7901 Independence Blvd., Baton Rouge, LA 70806	9:00 AM or 2:00 PM
October 1	Alexandria Convention Center 2225 N MacArthur Dr., Alexandria, LA 71303	9:00 AM or 2:00 PM
October 14	University of New Orleans (University Center Ballroom) 2000 Lakeshore Drive, New Orleans, LA 70148	9:00 AM or 2:00 PM
October 14	West Monroe Convention Center 901 Ridge Avenue, West Monroe, LA 71291	9:00 AM or 2:00 PM
October 22	Southeastern Louisiana University Alumni Welcome Center 500 W University Ave, Hammond, LA 70401	9:00 AM or 2:00 PM
October 28	Houma - Terrebonne Civic Center 346 Civic Center Blvd., Houma, LA 70360	9:00 AM or 2:00 PM
October 28	Bossier City Civic Center 620 Benton Road, Bossier City, LA 71111	9:00 AM or 2:00 PM
November 4	Lake Charles Civic Center - Contraband Room 900 Lakeshore Drive, Lake Charles, LA 70602	9:00 AM or 2:00 PM
November 12	University of Louisiana-Lafayette Cecil J. Picard Center 200 East Devalcourt Street, Lafayette, LA 70506	9:00 AM or 2:00 PM

Visit ogb.la.gov or call 1-800-272-8451 for more information.

NOTES

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GENERAL INFORMATION

For all members

Annual Enrollment & Your Responsibilities

Important Dates

- **October 1, 2026** – 2027 OGB annual enrollment begins
- **November 15, 2026** – OGB annual enrollment ends
- **January 1, 2027** –New plan year begins

Your Responsibilities as an OGB Member

As an OGB member, you have access to comprehensive health benefit options for yourself and your eligible dependents. Here are some important points to keep in mind during annual enrollment:

During Annual Enrollment, You May:

- Change your health plan selection.
- Apply for term life insurance. (Evidence of insurability may apply.)
- Drop or add eligible dependents.
- Discontinue OGB coverage.

Your Responsibilities Include:

- Making or changing your selection by the deadline of November 15, 2026, either online or through your Human Resources department.
- Providing documentation to OGB if adding dependents. This documentation may include birth certificates, marriage certificates, or other acceptable legal or verification documents. Ensure documentation is submitted by the November 15, 2026 deadline.
- Educating yourself on the Plan materials to understand your options and coverage.
- Reviewing all communications from OGB and taking the required actions promptly.
- Verifying that your insurance premium deduction is correct in January.

Taking these steps ensures that you make informed decisions about your healthcare coverage and that your enrollment information is accurate and up to date. If you have any questions or need assistance, don't hesitate to reach out to OGB for support.

IMPORTANT! If you would like to remain in your current OGB health and/or term life insurance Plan with the same covered dependents for the 2027 Plan Year, you do not need to do anything. Your current coverage will continue for the 2027 Plan Year.

Making Your Health Plan Selection

Choose one of the following enrollment options:

LaGov vs. Non-LaGov

"LaGov" and "Non-LaGov" are agency classifications used by OGB. If you are uncertain about whether your agency is classified as LaGov or Non-LaGov, you should contact your human resources department.

ACTIVE EMPLOYEES, REHIRED RETIREES	OGB Annual Enrollment Portal	Louisiana Employees On-line (LEO)	Human Resources Department
Enroll in a new health plan with the same covered dependents as 2026	✓ (Non-LaGov employees only)	✓ (LaGov employees only)	✓
Enroll in a health plan with different or new covered dependents than 2026			✓
Elect or re-elect HSA contributions	✓ (Re-elect) (Non-LaGov employees only)	✓ (Re-elect) (LaGov employees only)	✓ (Elect)
Elect or re-elect FSA contributions	✓ (Non-LaGov employees only)	✓ (LaGov employees only)	✓
Apply for term life insurance or make a change to term life insurance coverage			✓
Discontinue OGB health and/or term life insurance coverage			✓

Access the web portal at ogb.la.gov.

Making Changes During the Plan Year

It's crucial to carefully consider your benefit needs and make the appropriate selection during the annual enrollment period. Keep in mind that once you've made your health plan selection, you will generally not be able to make changes until the next annual enrollment period, unless you experience an OGB Plan-Recognized Qualified Life Event during the plan year.

What You Need to Know:

- **Annual Enrollment Limitation:** Changes to your health plan selection are typically limited to the annual enrollment period.
- **Exceptions for Qualified Life Events:** You may be eligible to make changes outside of the annual enrollment period if you experience an OGB Plan-Recognized Qualified Life Event during the plan year.
- **Understanding Qualified Life Events:** A Qualified Life Event is a significant life change that may affect your healthcare needs or eligibility for coverage.

Take Action When Necessary:

- If you experience a Qualified Life Event, be sure to familiarize yourself with the process for making changes to your health plan.
- Promptly notify OGB of any Qualified Life Event and follow the required steps to update your coverage accordingly.

By staying informed about your options and understanding the circumstances under which you can make changes to your health plan, you can ensure that your coverage aligns with your evolving needs and life circumstances.

Eligibility & Dependent Coverage

You can enroll eligible dependents in your OGB health plan during annual enrollment or within 30 days of a qualifying life event. Here's who qualifies and what documentation is required:

Who Can You Cover?

Spouse

- Your legal spouse

Children (up to age limit unless otherwise eligible)

Includes:

- Your biological child
- Your legal spouse's child (stepchild)
- Legally adopted child
- Child placed with you for adoption

Other Eligible Non-Spouse Dependents

- Unmarried grandchild for whom you have legal custody and who lives with you
- Unmarried child for whom you have court-ordered legal custody

Required Documentation (Due Within 30 Days of Eligibility)

The following requirements and associated documentation must be submitted to OGB in order to have your dependent covered under your OGB health plan:

Spouse

- A copy of the marriage certificate

Child

- Copy of child's birth certificate or birth letter

Stepchild(ren)

- A copy of the marriage certificate between the member and biological parent
- A copy of stepchild(ren)'s birth certificate

Legal Custody Dependent

- Legal custody must be granted by the court before the dependent(s) turns 18 years of age
- Legal dependent(s) may remain covered until age 18
- Required documents
    - Copy of legal custody decree
    - Copy of dependent's birth certificate

Grandchildren

- Legal custody must be granted by the court before grandchild turns 18 years of age
- Unmarried grandchild may remain covered until age 26
- Required documents:
    - A copy of legal custody decree
    - A copy of grandchild(ren)'s birth certificate

Reminder: Be sure to submit all dependent verification documents to OGB within 30 days of the dependent becoming eligible to ensure coverage.

REMINDER! Add Your Newborn – Don't Miss the Deadline!

To enroll your newborn, submit an application and a birth certificate or birth letter (showing your relationship) within 30 days of birth.

If not received on time, you'll need to wait for Annual Enrollment or another Qualified Life Event to add your child.

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SUMMARY OF PLANS

Active Employees & Rehired Retirees

Pelican HRA1000

The Pelican HRA1000 plan is designed to provide financial support for your healthcare expenses through a health reimbursement account (HRA). Here are the key features of this plan:

- **Annual Employer Contributions:** Receive $1,000 for employee-only plans and $2,000 for employee plus dependent(s) plans deposited into your HRA each year.
- **Offset Healthcare Costs:** Use these funds to help cover your deductible and other out-of-pocket healthcare expenses throughout the year.
- **Rollover Benefits:** Any unused funds in your HRA will roll over to the next plan year, up to the In-Network out-of-pocket maximum, as long as you stay enrolled in the Pelican HRA1000 plan. This allows you to accumulate funds for future medical expenses. Funds are forfeited when you leave the HRA plan or the plan is no longer offered.

The Pelican HRA1000 plan offers a practical way to manage and reduce your healthcare costs with the added benefit of building a financial cushion for future medical needs.

	Employee Only	Family
Annual Employer Contribution to HRA	$1,000	$2,000
Deductible (In-Network)	$2,000	$4,000
Deductible (Out-of-Network)	$4,000	$8,000
Out-of-pocket max (In-Network)	$5,000	$10,000
Out-of-pocket max (Out-of-Network)	$10,000	$20,000
Coinsurance (In-Network)	20%	20%
Coinsurance (Out-of-Network)	40%	40%

Pharmacy Benefits

OGB uses a Formulary to help members select the most appropriate, lowest-cost options. The Formulary is reviewed regularly to reassess drug tiers based on the current prescription drug market. Members will continue to pay a portion of the cost of their prescriptions in the form of a copay or coinsurance. The amount members pay toward their prescription depends on whether or not they receive a generic, preferred, non-preferred, or specialty brand drug.

Tier	Member Responsibility*
Generic	50% up to $30
Preferred	50% up to $55
Non-Preferred	65% up to $80
Specialty	50% up to $80
After the out-of-pocket threshold amount of $1,500 is met by you and/or your covered dependent(s):	
Generic	$0 copay
Preferred	$20 copay
Non-Preferred	$40 copay
Specialty	$40 copay

**Member responsibility is for a prescription drug benefit of up to a 31- day supply. *For medications with a 32–62 day supply, the member copay would be 2 times the applicable tier copay. *For medications with a 63–93 day supply, the member copay would be 3 times the applicable tier copay.*

Pelican HSA775 (Active Employees Only)*

The Pelican HSA775 plan offers the lowest premiums among our options and includes a separate health savings account (HSA) funded by both employers and employees. Here are the key features:

Employer and Employee Contributions:

- Employers contribute $200 to the HSA.
- Employers also match any employee contributions up to an additional $575.
- Employees can contribute to their HSA on a pre-tax basis.

Contribution Limits:

- Individuals can contribute up to $4,500 annually to their HSA to cover out-of-pocket medical and pharmacy costs.
- Families can contribute up to $9,000 to cover out-of-pocket medical and pharmacy costs.

Annual Enrollment Process:

- A Health Savings Account Enrollment & Payroll Deduction Election/Change Form (GB-79 form) must be filled out each year during Annual Enrollment for the following year's contributions.

Tax Implications:

- Tax implications may apply for certain members. Visit www.irs.gov for more information.

Medicare Eligibility:

- Active employees who become eligible for Medicare will no longer be able to contribute to their health savings account.

	Employee Only	Family
Employer Contribution to HSA	$200, plus up to $575 dollar-for-dollar match of employee contributions	
Deductible (In-Network)	$2,000	$4,000
Deductible (Out-of-Network)	$4,000	$8,000
Out-of-pocket max (In-Network)	$5,000	$10,000
Out-of-pocket max (Out-of-Network)	$10,000	$20,000
Coinsurance (In-Network)	20%	20%
Coinsurance (Out-of-Network)	40%	40%

Pharmacy Benefits

OGB uses a Formulary to help members select the most appropriate, lowest-cost options. The Formulary is reviewed regularly to reassess drug tiers based on the current prescription drug market. Members will continue to pay a portion of the cost of their prescriptions in the form of a copay or coinsurance. The amount members pay toward their prescription depends on whether or not they receive a generic, preferred, non-preferred, or specialty brand drug. Member enrolled in the Pelican Has will not have a pharmacy out of pocket threshold, however, you must meet your medical deductible based on your level of coverage to receive the following co-pay:

Tier	Member Responsibility*
Generic	$10 copay (31 day supply)
Preferred	$25 copay (31 day supply)
Non-Preferred	$50 co pay (31 day supply)
Specialty	$50 co pay (31 day supply)

**Maintenance medications are not subject to the deductible, but are subject to the pharmacy copay format above. Please visit the Liviniti website to view those medications.*

HealthEquity®

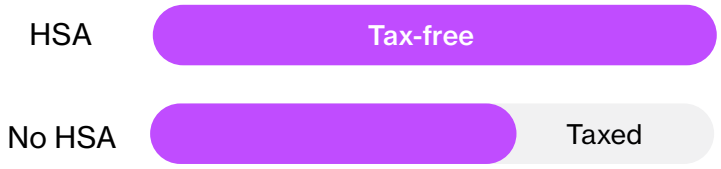
Health Savings Account

An HSA lets you save money for future healthcare costs while also saving on taxes. How? HSAs are the only benefit with a triple-tax advantage:[1] Tax-free contributions. Tax-free account growth. And tax-free spending on HSA-qualified expenses. It's your healthcare emergency safety net.

- Rolls over every year – funds never expire
- Available tax-free investing, just like a 401(k)[2]
- Requires an eligible high-deductible health plan (HDHP)

Less tax.
More paycheck.

Get $30 tax savings for every $100 you contribute.[3]



2027 HSA Contribution Limits

$4,500
Individual plan

$9,000
Family plan

Members 55+ can contribute an extra $1,000.

See how much you can save.

HealthEquity.com/Learn/HSA

Scan to download the HealthEquity mobile app.



You can set up your account directly in the app – no need to register online.

Spend tax-free on HSA-qualified expenses.

- Medical
- Dental
- Vision
- Rx and OTC

Discover more: HealthEquity.com/QME

[1]HSAs are federally tax-deductible for qualified medical expenses and usually state-deductible; consult a tax advisor for details. | [2]Investments are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. Investing through the HealthEquity investment platform is subject to the terms and conditions of the Health Savings Account Custodial Agreement and any applicable investment supplement. | [3]Example for illustration only; savings based on a 30% federal and state tax bracket. | HealthEquity does not provide legal, tax or financial advice.

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Magnolia Local Plus (Nationwide In-Network Providers)

The Magnolia Local Plus plan offers comprehensive coverage with a focus on predictability and access to a broad network of providers. Here are the key features:

- **Nationwide In-Network Providers:** Access an extensive network of In-Network providers across the country. There is no out-of-network coverage with this plan, except in the event of an emergency.
- **Predictable Costs:** Enjoy the consistency of copays for healthcare services instead of relying on employer funding to cover out-of-pocket expenses.
- **Emergency Coverage:** Out-of-Network care is covered only in emergencies, with the possibility of balance billing for any costs not covered by the insurance.

The Magnolia Local Plus plan is designed for those who prefer predictable copays and broad access to In-Network providers, ensuring comprehensive care with manageable costs.

Non-Medicare Retirees (retirement date ON or AFTER 3-1-2015)	Employee Only	Employee + 1	Employee + 2 or more
Deductible (In-Network)	$400	$800	$1,200
Deductible (Out-of-Network)	No coverage	No coverage	No coverage
Out-of-pocket max (In-Network)	$3,500	$6,000	$8,500
Out-of-pocket max (Out-of-Network)	No coverage	No coverage	No coverage
Copay (In-Network) PCP/SPC[3]	$25 / $50	$25 / $50	$25 / $50
Non-Medicare Retirees (retirement date BEFORE 3-1-2015)			
Deductible (In-Network)	$0	$0	$0
Deductible (Out-of-Network)	No coverage	No coverage	No coverage
Out-of-pocket max (In-Network)	$2,000	$3,000	$4,000
Out-of-pocket max (Out-of-Network)	No coverage	No coverage	No coverage
Copay (In-Network) PCP/SPC[3]	$25 / $50	$25 / $50	$25 / $50

Pharmacy Benefits

OGB uses a Formulary to help members select the most appropriate, lowest-cost options. The Formulary is reviewed regularly to reassess drug tiers based on the current prescription drug market. Members will continue to pay a portion of the cost of their prescriptions in the form of a copay or coinsurance. The amount members pay toward their prescription depends on whether or not they receive a generic, preferred, non-preferred, or specialty brand drug.

Tier	Member Responsibility*
Generic	50% up to $30
Preferred	50% up to $55
Non-Preferred	65% up to $80
Specialty	50% up to $80
After the out-of-pocket threshold amount of $1,500 is met by you and/or your covered dependent(s):	
Generic	$0 copay
Preferred	$20 copay
Non-Preferred	$40 copay
Specialty	$40 copay

**Member responsibility is for a prescription drug benefit of up to a 31- day supply. *For medications with a 32–62 day supply, the member copay would be 2 times the applicable tier copay. *For medications with a 63–93 day supply, the member copay would be 3 times the applicable tier copay.*

Magnolia Open Access (Nationwide Providers)

The Magnolia Open Access Plan offers flexible coverage with both **In-Network and Out-of-Network** options. Here's a summary of its features:

- **Nationwide Coverage:** Access to a nationwide network of providers, offering flexibility for members who live out of state or travel frequently.
- **Cost Structure:** Instead of copays, you pay a percentage of costs after meeting your deductible:
  - **In-Network Care:** Pay 10% of the allowable amount after meeting the deductible.
  - **Out-of-Network Care**: Pay 30% of the allowable amount after meeting the deductible, with the potential for balance billing.

The Magnolia Open Access Plan is ideal for members who value extensive network access and flexibility, especially those who may need care while traveling or living out of state.

Non-Medicare Retirees (retirement date ON or AFTER 3-1-2015)	Employee Only	Employee + 1	Employee + 2 or more
Deductible (In-Network)	$900	$1,800	$2,700
Deductible (Out-of-Network)	$900	$1,800	$2,700
Out-of-pocket max (In-Network)	$3,500	$6,000	$8,500
Out-of-pocket max (Out-of-Network)	$4,700	$8,500	$12,250
Coinsurance (In-Network)	10%	10%	10%
Coinsurance (Out-of-Network)	30%	30%	30%
Non-Medicare Retirees (retirement date BEFORE 3-1-2015)			
Deductible (In-Network)	$300	$600	$900
Deductible (Out-of-Network)	$300	$600	$900
Out-of-pocket max (In-Network)	$2,300	$3,600	$4,900
Out-of-pocket max (Out-of-Network)	$4,300	$7,600	$10,900
Coinsurance (In-Network)	10%	10%	10%
Coinsurance (Out-of-Network)	30%	30%	30%

Pharmacy Benefits

OGB uses a Formulary to help members select the most appropriate, lowest-cost options. The Formulary is reviewed regularly to reassess drug tiers based on the current prescription drug market. Members will continue to pay a portion of the cost of their prescriptions in the form of a copay or coinsurance. The amount members pay toward their prescription depends on whether or not they receive a generic, preferred, non-preferred, or specialty brand drug.

Tier	Member Responsibility*
Generic	50% up to $30
Preferred	50% up to $55
Non-Preferred	65% up to $80
Specialty	50% up to $80
After the out-of-pocket threshold amount of $1,500 is met by you and/or your covered dependent(s):	
Generic	$0 copay
Preferred	$20 copay
Non-Preferred	$40 copay
Specialty	$40 copay

**Member responsibility is for a prescription drug benefit of up to a 31- day supply. *For medications with a 32–62 day supply, the member copay would be 2 times the applicable tier copay. *For medications with a 63–93 day supply, the member copay would be 3 times the applicable tier copay.*

Magnolia Local (Select, In-Network Provider Only Plan)

The Magnolia Local plan is a select, **In-Network provider only** plan for members who live in specific coverage areas. Magnolia Local is a health plan for members who want local access, affordable premiums and a new approach to healthcare. Out-of-Network care is covered only in emergencies, and the member may be balance-billed.

What is different about Magnolia Local?

- **Your network of doctors and hospitals is more defined** than other plans. You still have a full network of primary care doctors, specialists and other healthcare providers in your area.
- **You have a coordinated care team** that talks to one another and helps you get the right care in the right place.
- **Staying in network is very important! Out-of-network coverage is provided only in the case of an emergency.**
- Where you live will determine which Magnolia Local network you will use.

Before you choose Magnolia Local, consider this:

- Which doctors/clinics do you go to the most?
- Which clinics/hospitals are closest to where you live?
- Staying in network is very important! As long as you receive care within your network, you will pay less than if you receive care outside of the network.

Magnolia Local has two networks: Community Blue & Blue Connect

Community Blue is a select, local network designed ***only*** for members who live in the parishes of **Ascension, East Baton Rouge, Livingston, and West Baton Rouge**.

Blue Connect is a select, local network designed ***only*** for members who live in the parishes of **Acadia, Bossier, Caddo, Evangeline, Iberia, Jefferson, Lafayette, Orleans, Plaquemines, St. Bernard, St. Charles, St. James, St. John the Baptist, St. Landry, St. Martin, St. Mary, St. Tammany, Terrebonne and Vermilion.**

Community Blue* (for residents in the Baton Rouge Region)

You have access to many healthcare providers in the following regions:

Baton Rouge Region

- Baton Rouge General Medical Center
- Ochsner Medical Center Baton Rouge
- The Baton Rouge Clinic*
- Ochsner Clinic
- BR General Physicians Group
- Ochsner The Grove

To find a complete list of providers in this network, visit **lablue.com/ogb** and choose your member type under Magnolia Local. Click Find a Doctor, then Find a Community Blue Doctor.

* Select physicians available at The Baton Rouge Clinic. Does not include gastroenterologist physicians.

Blue Connect* (New Orleans, Northshore, Lafayette, Bayou and Shreveport/Bossier Regions)

You have access to many healthcare providers in the following regions, including:

Greater New Orleans/Bayou Regions

- Ochsner Health and its affiliates
- Terrebonne General Medical Center
- Leonard J. Chabert Medical Center

Lafayette Region

- Ochsner Lafayette General and its affiliates
- Opelousas General Health System
- Ochsner Abrom Kaplan Memorial Hospital
- Abbeville General Hospital
- Iberia Medical Center

St. Tammany Region

- Ochsner Medical Center Northshore
- St. Tammany Hospital System
- Slidell Memorial Hospital

Shreveport/Bossier Region

- CHRISTUS Shreveport-Bossier Health System and its affiliates

**Providers in the Community Blue and Blue Connect networks are subject to change. View Louisiana Blue's network providers at ogb.la.gov.*

IMPORTANT! Magnolia Local is a perfect fit for some, but not others. We encourage you to carefully review the doctors/clinics/hospitals within the Community Blue and Blue Connect networks before selecting this option.

Active employees and Non-Medicare Retirees (retirement date ON or AFTER 3-1-2015)	Employee Only	Employee + 1	Employee + 2 or more
Deductible (In-Network)	$400	$800	$1,200
Deductible (Out-of-Network)	No coverage	No coverage	No coverage
Out-of-pocket max (In-Network)	$2,500	$5,000	$7,500
Out-of-pocket max (Out-of-Network)	No coverage	No coverage	No coverage
Copay (In-Network) PCP/SPC	$25 / $50	$25 / $50	$25 / $50
Non-Medicare Retirees (retirement date BEFORE 3-1-2015)			
Deductible (In-Network)	$0	$0	$0
Deductible (Out-of-Network)	No coverage	No coverage	No coverage
Out-of-pocket max (In-Network)	$1,000	$2,000	$3,000
Out-of-pocket max (Out-of-Network)	No coverage	No coverage	No coverage
Copay (In-Network) PCP/SPC	$25 / $50	$25 / $50	$25 / $50

Pharmacy Benefits

OGB uses a Formulary to help members select the most appropriate, lowest-cost options. The Formulary is reviewed regularly to reassess drug tiers based on the current prescription drug market. Members will continue to pay a portion of the cost of their prescriptions in the form of a copay or coinsurance. The amount members pay toward their prescription depends on whether or not they receive a generic, preferred, non-preferred, or specialty brand drug.

Tier	Member Responsibility*
Generic	50% up to $30
Preferred	50% up to $55
Non-Preferred	65% up to $80
Specialty	50% up to $80
After the out-of-pocket threshold amount of $1,500 is met by you and/or your covered dependent(s):	
Generic	$0 copay
Preferred	$20 copay
Non-Preferred	$40 copay
Specialty	$40 copay

**Member responsibility is for a prescription drug benefit of up to a 31- day supply. *For medications with a 32–62 day supply, the member copay would be 2 times the applicable tier copay. *For medications with a 63–93 day supply, the member copay would be 3 times the applicable tier copay.*

We encourage you to make sure you choose a doctor or hospital in your provider network when you need healthcare. By choosing a network provider, you avoid the possibility of having your provider bill you for amounts in addition to applicable copays, coinsurance, deductibles and non-covered services.

NOTES

LIVINITI

Member Reference Guide

Your Pharmacy ID Card Includes Important Information

Group Number:	**Found on your Member ID Card**
Member ID:	**Found on your Member ID Card**
Bin Number:	**025945**
PCN:	**SSN** **(SSN is a network acronym – it does not refer to your social security number)**
PBM:	**Liviniti**

Contact Information

We're here 24/7/365 to support plan members

- Call us: 833-925-2770
- Send a fax: (318) 214-4190
- Send an email: support@liviniti.com
- Visit: liviniti.com

Find What You Need

The Liviniti **Member Center** is your one-stop hub for all the information you need to maximize your pharmacy benefits.

The **Member Portal** is loaded with information about your pharmacy benefits and prescriptions. After you create your account and confirm your registration, you can login to the Member Portal from the Member Center.

On the Member Portal you can:

- View benefit details, including out-of-pocket and deductible information for you and your family
- Review your prescription history and share it with your physician
- Search for a nearby pharmacy based on your zip code
- Find and compare drug prices to find the best price at any network pharmacy in a few easy steps
- Search for medications by name and view formulary tier, whether it is a specialty or over-the-counter (OTC) drug, and any special programs such as prior authorization or quantity limits that apply to the medication
- Check the history or status of any prior authorization
- Locate the mail order pharmacy used by your plan
- Download a digital ID card

Activate your Member Portal:

1. Visit liviniti.com/members
2. Under Member Portal Login, select "Create Account"
   - Refer to your ID card for your credentials
   - Choose a password
   - Click "Register"
3. You will receive an email to confirm your registration before you can login

Member Reference Guide

Find What You Need (continued)

Take your pharmacy benefits on the go with the Liviniti Mobile App.

The mobile app has the same features and information as the Member Portal. You can find a free copy of the Liviniti Mobile App wherever you download apps for your phone. Get started today!

iPhone QR Code

Android QR Code

Your **Company Page** also has helpful information. You do not need to create a personal account but will need your Group Number. On the Member Center, scroll down to Your Company Page, enter your Group Number and click "Visit Company Page."

On your Company Page you can:

- Find your plan's Formulary or Drug List and look-up a drug or learn more about your coverage
  - Use your Group Number to access your Company Page
  - Under **Search For Medications**, type the name of your medication and click Search
- Locate the best network pharmacy for your needs based on the zip code you enter
  - Use your Group Number to access your Company Page
  - Select **Network Pharmacy Locator***
  - Enter your ZIP code
  - Enter the Liviniti Bin Number: 025945
  - Choose your search radius and select "Search"

***These symbols are in the Network Pharmacy Locator**

firstchoice

Pharmacy is contracted as a FirstChoice pharmacy

Pharmacy is contracted for specialty medications

Pharmacy is contracted for vaccines

What is the FirstChoice™ Pharmacy Network?

FirstChoice is the preferred pharmacy network of Liviniti. You'll find reduced prescription costs at network pharmacies that generally offer a lower cost on medications than a standard (non-preferred) pharmacy. The network consists of independent, community pharmacies as well as well-known regional or national chains. Participating pharmacies are approved to fill a 90-day supply of medications. Specialty medications are limited to a 30-day supply.

How to Enroll - LaGov Employees

During annual enrollment, members have the flexibility to make changes to their current health plans, renew their HSA (Health Savings Account) and/or FSA (Flexible Spending Account) contributions, switch to a new health plan, or choose to maintain their current coverage. However, how you make these changes depends on your member status and agency classification, specifically whether you fall under "LaGov" or "Non-LaGov" classifications.

LaGov vs. Non-LaGov

- **LaGov:** This classification refers to agencies categorized as part of the Louisiana state government.
- **Non-LaGov:** This classification includes agencies that are not part of the Louisiana state government.

If you are uncertain about whether your agency is classified as LaGov or Non-LaGov, it's essential to contact your human resources department for clarification.

Active LaGov Employees

There are two ways for active employees to change their health plan:

1. **Louisiana Employees Online (LEO):**
   - Active LaGov employees can change or update their health plan elections through Louisiana Employees Online (LEO).
   - Instructions for using LEO will be provided by the human resources department prior to the start of the annual enrollment period.
2. **Contact Your Human Resources Department:**
   - Alternatively, active employees can contact their human resources department for assistance with changing their health plan.

Important Note: Active employees should not submit a paper enrollment form to OGB. It will not be accepted.

Choose the method that works best for you to ensure a smooth and accurate transition or update to your health plan coverage. If you have any questions or need further assistance, your human resources department will be able to provide guidance.

LaGov Rehired Retirees

LaGov rehired retirees have the option to change or update their health plan elections by contacting their human resources department. If you fall into this category and wish to make changes to your health plan, reaching out to your Human Resources department is the appropriate course of action. They will provide guidance and assistance to ensure that your health plan elections are accurately updated according to your preferences and needs

IMPORTANT! If you would like to remain in your current OGB health plan with the same covered dependents for the 2027 Plan Year, you do not need to do anything. Your coverage will continue for the 2027 Plan Year. **(Active Members enrolled in the HSA and/or FSA options will need to update their elections for 2027.)**

How to Enroll - Non-LaGov Employees

Active Non-LaGov Employees

For active Non-LaGov employees, there are two options to change their health plan:

1. **OGB's Annual Enrollment Web Portal:**
   - Active Non-LaGov employees can change or update their health plan elections through OGB's annual enrollment web portal at ogb.la.gov.
   - To access the web portal, employees will need their insurance cards and identification numbers, such as their date of birth and Social Security number.
   - Please note that adding or removing dependents cannot be completed through the web portal. Adding or removing dependents must be completed through your Human Resources department. However, FSA (Flexible Spending Account) and HSA (Health Savings Account) contributions must be renewed annually and can be completed through the web portal.
2. **Contact Your Human Resources Department:**
   - Alternatively, active Non-LaGov employees can contact their human resources department for assistance with changing their health plan.

Important Note: Paper enrollment forms will not be accepted from active employees. It's essential to utilize the designated channels provided to make changes to your health plan elections.

Choose the method that aligns with your preferences and needs to ensure a seamless process for updating your health plan coverage. If you have any questions or need further assistance, your human resources department will be able to provide guidance and support.

Non-LaGov Rehired Retirees

There are four ways to change a health plan. Choose the one that works best for you:

1. Non-LaGov Rehired Retirees:

- Change or update your elections through OGB's annual enrollment web portal at ogb.la.gov.
  - You will need your identification numbers (such as your date of birth, Social Security number, etc.) to log in to the web portal.

2. Contact Your Human Resources Department:

- Reach out to your human resources department for assistance with changing your health plan.

3. To Enroll in a Health Plan with Different or New Covered Dependents, or to Discontinue OGB Coverage:

- Rehired Retirees must see their Human Resources department to add or drop dependents or discontinue their OGB coverage.

How to Enroll

Non-Medicare Retirees

There are three ways to change a health plan. Choose one that works best for you :

1. Non-Medicare retirees may change and/or update their elections through OGB's annual enrollment web portal - ***ogb.la.gov***
    - Retirees will need their insurance cards and identification numbers (date of birth, Social Security number, etc.) to log in to the web portal.
2. Complete the annual enrollment form found on page 19 and return it to the address provided by November 15.
3. To enroll in a health plan with different or new covered dependents or to discontinue OGB coverage:
    - Non-Medicare Retirees* can submit a dated and signed letter to OGB that includes:
        - the member's Social Security number;
        - new dependent's name, birth date and Social Security number; and
        - dependent verification documentation (i.e.- marriage and/or birth certificate).
        - **Please Note:** If you are dropping your OGB coverage entirely, you will not be able to get it back.
        - **Mail to**: Office of Group Benefits, Annual Enrollment, P.O. Box 44036, Baton Rouge, LA 70804; or
        - **Email to:** OGB.CustomerService@la.gov; or
        - **Fax to:** (225) 342-9917 or (225) 342-9919.

**Rehired Retirees must see their HR department to for any coverage changes..*

IMPORTANT! If you would like to remain in your current OGB health plan with the same covered dependents for the 2027 Plan Year, you do not need to do anything. Your coverage will continue for the 2027 Plan Year.

OFFICE OF GROUP BENEFITS

2027 ANNUAL ENROLLMENT FORM

Non-Medicare Retirees

(Please PRINT Clearly)

Plan Member's Name: _____

Address: _____

City, State, ZIP: _____

SSN: _____ **Phone:** (_____) _____

Personal Email Address: _____

NO ACTION IS NECESSARY IF YOU DO NOT WISH TO MAKE A CHANGE.

IF YOU WISH TO MAKE A CHANGE, PLEASE MARK ONE AND ONLY ONE SELECTION BY PLACING AN (X) IN THE APPROPRIATE BOX

- ☐ R — **Pelican HRA1000** *Administered by LA Blue*
- ☐ P — **Magnolia Local Plus** *Administered by LA Blue*
- ☐ A — **Magnolia Open Access** *Administered by LA Blue*
- ☐ L — **Magnolia Local (Limited In-Network Provider Network)** *Administered by LA Blue*

PLEASE MAIL, FAX OR EMAIL THIS FORM TO OGB BY NOVEMBER 15, 2026.

By Mail: Office of Group Benefits
Annual Enrollment
P.O. Box 44036
Baton Rouge, LA 70804

By Fax: Office of Group Benefits
Annual Enrollment
(225) 342-9917
or
(225) 342-9919

By Email: OGB.CustomerService@la.gov

_____ _____

Plan Member's Signature *(required)* **Date**

CUT ALONG DOTTED LINES

How to Read Your Benefits Comparison

Your Benefits Comparison has 3 main sections:

1

Cost Comparison

A comparison of the different Copays, Coinsurance, and Deductibles across offered plans. A Copay is a fixed payment for a covered service, and does not count toward your Deductible. A Coinsurance is the amount you pay for certain services after you have met your deductible. A Deductible is the amount you pay annually before your insurance begins to pay.

2

Out-of-Pocket Comparison

A comparison of the different Out-of-Pocket Maximums across offered plans. An Out-of-Pocket Maximum is the most you'll have to pay annually for health care services. Deductibles, Copays, Coinsurance and other medical expenses count toward your Out-of-Pocket Maximum. Your monthly premium does not.

3

Plan Benefits Summary

A high-level comparison of the benefits offered across each plan. Use to compare the different Copays, Coinsurance and Deductibles you may be responsible for when using different medical and pharmacy benefits. **This comparison chart is a summary of plan features and is presented for general information only. For a complete list of plan features, please review the plan documents posted on-line at ogb.la.gov.**

Choose a Plan Structure and Network: Some plan types allow you to use almost any doctor or health care facility. Others limit your choices, have no out-of-network coverage or charge you more if you use providers outside the network.

Compare Out-of-Pocket Costs

You may want a plan with low out-of-pocket costs if:

- You see a doctor, such as a specialist, on a regular basis
- You frequently need emergency care
- You take expensive or brand-name medications on a regular basis
- You are expecting a baby, plan to have a baby, or have small children
- You have a planned surgery coming up
- You've recently been diagnosed with a chronic condition such as diabetes or cancer

You may want a plan with higher out-of-pocket costs if:

- You cannot afford a plan with lower out-of-pocket costs
- You are in good health and rarely see a doctor
- You rarely participate in activities with a high risk of injury

Compare Covered Benefits

- Compare the Copay, Coinsurance and Deductible of any planned services or procedures for the upcoming plan year.
- See if your physician or preferred facility is covered under each plan by visiting **lablue.com/ogb**
- Review your prescription cost across plans by searching the formularies for each plan. If you are on maintenance medications, consider mail order to reduce costs.

ACTIVE EMPLOYEES and NON-MEDICARE RETIREES
(RETIREMENT DATE ON or AFTER March 1, 2015)
Pelican Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	PELICAN HRA1000 High Deductible Health Plan		PELICAN HSA775 High Deductible Health Plan	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE				
EMPLOYEE ONLY	$2,000	$4,000	$2,000	$4,000
FAMILY	$4,000	$8,000	$4,000	$8,000
OUT-OF-POCKET MAXIMUM				
EMPLOYEE ONLY	$5,000	$10,000	$5,000	$10,000
FAMILY	$10,000	$20,000	$10,000	$20,000
STATE FUNDING	**THE PLAN PAYS**		**THE PLAN PAYS**	
EMPLOYEE ONLY	**$1,000**		**$775***	
FAMILY	**$2,000**		**$775***	
	Funding not applicable to pharmacy Expenses.		*$200, plus up to $575 more dollar for dollar match of employee contributions	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICIANS' SERVICES				
Preventative Care Primary Care Physician or Specialist Office or Clinic	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
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
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
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
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
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
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
HOSPITAL SERVICES				
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
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

This comparison chart is a summary of plan features and is presented for general information only. It is not a guarantee of coverage.
NOTE: Prior Authorizations and Visit Limits may apply to some benefits - refer to your Plan Document for details.

ACTIVE EMPLOYEES and NON-MEDICARE RETIREES
(RETIREMENT DATE ON or AFTER March 1, 2015)
Pelican Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	PELICAN HRA1000 High Deductible Health Plan		PELICAN HSA775 High Deductible Health Plan	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
HOSPITAL SERVICES				
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
BEHAVIORAL HEALTH				
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
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
OTHER COVERAGE				
Outpatient Acute Short-Term Rehabilitation Services Physical Therapy, Speech Therapy, Occupational Therapy, etc.	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Chiropractic Care	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Urgent Care Center	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Home Health Care Services	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Skilled Nursing Facility Services	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Hospice Care	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
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
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
Transplant Services	80% coverage; subject to deductible	NO COVERAGE	80% coverage; subject to deductible	NO COVERAGE
PHARMACY				
Tier 1 - Generic	50% up to $30 [1]		$10 Copay	
Tier 2 - Preferred	50% up to $55 [1,2]		$25 copay	
Tier 3 - Non-Preferred	65% up to $80 [1,2]		$50 copay	
Tier 4 - Specialty	50% up to $80 [1,2]		$50 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		Does Not Apply	
Tier 2 - Preferred	$20 copay		Does Not Apply	
Tier 3 - Non-Preferred	$40 copay		Does Not Apply	
Tier 4 - Specialty	$40 copay		Does Not Apply	

[1]Prescription drug benefit - 31-day fill
For medications with a 32–62 day supply, the member copay would be 2 times the applicable tier copay.
For medications with a 63–93 day supply, the member copay would be 3 times the applicable tier copay.
[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).

ACTIVE EMPLOYEES and NON-MEDICARE RETIREES
(RETIREMENT DATE ON or AFTER March 1, 2015)
Magnolia Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	MAGNOLIA LOCAL		MAGNOLIA LOCAL PLUS		MAGNOLIA OPEN ACCESS	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE						
EMPLOYEE ONLY	$400	NO COVERAGE	$400	NO COVERAGE	$900	$900
EMPLOYEE + 1	$800	NO COVERAGE	$800	NO COVERAGE	$1,800	$1,800
EMPLOYEE + 2 OR MORE	$1,200	NO COVERAGE	$1,200	NO COVERAGE	$2,700	$2,700
OUT-OF-POCKET MAXIMUM						
EMPLOYEE ONLY	$2,500	NO COVERAGE	$3,500	NO COVERAGE	$3,500	$4,700
EMPLOYEE + 1	$5,000	NO COVERAGE	$6,000	NO COVERAGE	$6,000	$8,500
EMPLOYEE + 2 OR MORE	$7,500	NO COVERAGE	$8,500	NO COVERAGE	$8,500	$12,250
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICIANS' SERVICES						
Preventative Care Primary Care Physician or Specialist Office or Clinic	100% coverage; not subject to deductible	NO COVERAGE	100% coverage; not subject to deductible	NO COVERAGE	100% coverage; not subject to deductible	70% coverage; subject to deductible
Primary Care Physician or Specialist Office - Treatment of illness or injury	100% coverage after a $25 PCP or $50 SPC copay per visit	NO COVERAGE	100% coverage after a $25 PCP or $50 SPC copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Maternity Care (prenatal, delivery and postpartum)	100% coverage; after a $90 copay per pregnancy	NO COVERAGE	100% coverage; after a $90 copay per pregnancy	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Physician Services Furnished in a Hospital Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist.	100% coverage; subject to deductible	NO COVERAGE	100% coverage; subject to deductible	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Physician Services for Emergency Room Care	100% coverage; subject to deductible	NO COVERAGE	100% coverage; subject to deductible	NO COVERAGE	90% coverage; subject to deductible	90% coverage; subject to deductible
Outpatient Surgery/ Services When billed as office visits	100% coverage; after a $25 PCP or $50 SPC copay per visit	NO COVERAGE	100% coverage; after a $25 PCP or $50 SPC copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Outpatient Surgery/ Services When billed as outpatient surgery at a facility	100% coverage; subject to deductible	NO COVERAGE	100% coverage; subject to deductible	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
HOSPITAL SERVICES						
Inpatient Services Inpatient care, delivery and inpatient short-term acute rehabilitation services	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	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible + $50 copay per day (days 1 - 50)
Outpatient Surgery/ Services Hospital / Facility	100% coverage; after a $100 facility copay per visit	NO COVERAGE	100% coverage; after a $100 facility copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible

ACTIVE EMPLOYEES and NON-MEDICARE RETIREES
(RETIREMENT DATE ON or AFTER March 1, 2015)
Magnolia Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	MAGNOLIA LOCAL		MAGNOLIA LOCAL PLUS		MAGNOLIA OPEN ACCESS	
COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
HOSPITAL SERVICES						
Emergency Room - Hospital (Facility) Treatment of an emergency medical condition or injury	100% coverage after $200 copay per visit; waived if admitted	NO COVERAGE	100% coverage after $200 copay per visit; waived if admitted	NO COVERAGE	90% coverage; subject to deductible; $200 copay per visit; waived if admitted	90% coverage; subject to deductible; $200 copay per visit; waived if admitted
BEHAVIORAL HEALTH						
Mental Health and Substance Abuse Inpatient Facility	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	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible + $50 copay per day (days -5)
Mental Health and Substance Abuse Outpatient Visits - Professional	100% coverage; after a $25 copay per visit	NO COVERAGE	100% coverage; after a $25 copay per isit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
OTHER COVERAGE						
Outpatient Acute Short-Term Rehabilitation Services Physical Therapy, Speech Therapy, Occupational Therapy, Other short term rehabilitative services	100% coverage; after a $25 copay per visit	NO COVERAGE	100% coverage; after a $25 copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Chiropractic Care	100% coverage; after a $25 copay per visit	NO COVERAGE	100% coverage; after a $25 copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Urgent Care Center	100% coverage after a $50 copay per visit	NO COVERAGE	100% coverage after a $50 copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Home Health Care Services	100% coverage subject to deductible	NO COVERAGE	100% coverage subject to deductible	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Skilled Nursing Facility Services	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	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Hospice Care	100% coverage subject to deductible	NO COVERAGE	100% coverage subject to deductible	NO COVERAGE	80% coverage; subject to deductible	70% coverage; subject to deductible
Durable Medical Equipment (DME) - Rental or Purchase	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; subject to deductible; 100% in excess of $5,000 per plan year	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible

ACTIVE EMPLOYEES and NON-MEDICARE RETIREES
(RETIREMENT DATE ON or AFTER March 1, 2015)
Magnolia Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	MAGNOLIA LOCAL		MAGNOLIA LOCAL PLUS		MAGNOLIA OPEN ACCESS	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
OTHER 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	90% coverage; subject to deductible	70% coverage; subject to deductible
Transplant Services	100% coverage; subject to deductible	NO COVERAGE	100% coverage; subject to deductible	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
PHARMACY						
Tier 1 - Generic	50% up to $30 [1]					
Tier 2 - Preferred	50% up to $55 [1,2]					
Tier 3 - Non-Preferred	65% up to $80 [1,2]					
Tier 4 - Specialty	50% up to $80 [1,2]					
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					
Tier 2 - Preferred	$20 copay					
Tier 3 - Non-Preferred	$40 copay					
Tier 4 - Specialty	$40 copay					

[1] Prescription drug benefit - 31-day fill

For medications with a 32–62 day supply, the member copay would be 2 times the applicable tier copay.

For medications with a 63–93 day supply, the member copay would be 3 times the applicable tier copay.

[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).

[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).

This comparison chart is a summary of plan features and is presented for general information only. It is not a guarantee of coverage.

NOTE: Prior Authorizations and Visit Limits may apply to some benefits - refer to your Plan Document for details.

NON-MEDICARE RETIREES
(RETIREMENT DATE BEFORE March 1, 2015)
Pelican Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	PELICAN HRA1000 High Deductible Health Plan	
	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
EMPLOYEE ONLY	$2,000	$4,000
FAMILY	$4,000	$8,000
OUT-OF-POCKET MAXIMUM		
EMPLOYEE ONLY	$5,000	$10,000
FAMILY	$10,000	$20,000
STATE FUNDING	**THE PLAN PAYS**	
EMPLOYEE ONLY	**$1,000**	
FAMILY	**$2,000**	
	Funding not applicable to pharmacy Expenses.	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICIANS' SERVICES		
Preventative Care Primary Care Physician or Specialist Office or Clinic	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
Primary Care Physician or Specialist Office - Treatment of illness or injury	80% coverage; subject to deductible	60% coverage; subject to deductible
Maternity Care (prenatal, delivery and postpartum)	80% coverage; subject to deductible	60% coverage; subject to deductible
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
Physician Services for Emergency Room Care	80% coverage; subject to deductible	80% coverage; subject to deductible
Outpatient Surgery/ Services When billed as office visits	80% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/ Services When billed as outpatient surgery at a facility	80% coverage; subject to deductible	60% coverage; subject to deductible
HOSPITAL SERVICES		
Inpatient Services Inpatient care, delivery and inpatient short-term acute rehabilitation services	80% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/Services Hospital / Facility	80% coverage; subject to deductible	60% coverage; subject to deductible

This comparison chart is a summary of plan features and is presented for general information only. It is not a guarantee of coverage.
NOTE: Prior Authorizations and Visit Limits may apply to some benefits - refer to your Plan Document for details.

NON-MEDICARE RETIREES
(RETIREMENT DATE BEFORE March 1, 2015)
Pelican Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	PELICAN HRA1000 High Deductible Health Plan	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
HOSPITAL SERVICES		
Emergency Room - Hospital (Facility) Treatment of an emergency medical condition or injury	80% coverage; subject to deductible	80% coverage; subject to deductible
BEHAVIORAL HEALTH		
Mental Health and Substance Abuse - Inpatient Facility	80% coverage; subject to deductible	60% coverage; subject to deductible
Mental Health and Substance Abuse Outpatient Visits - Professional	80% coverage; subject to deductible	60% coverage; subject to deductible
OTHER COVERAGE		
Outpatient Acute Short-Term Rehabilitation Services Physical Therapy, Speech Therapy, Occupational Therapy, etc.	80% coverage; subject to deductible	60% coverage; subject to deductible
Chiropractic Care	80% coverage; subject to deductible	60% coverage; subject to deductible
Urgent Care Center	80% coverage; subject to deductible	60% coverage; subject to deductible
Home Health Care Services	80% coverage; subject to deductible	60% coverage; subject to deductible
Skilled Nursing Facility Services	80% coverage; subject to deductible	60% coverage; subject to deductible
Hospice Care	80% coverage; subject to deductible	60% coverage; subject to deductible
Durable Medical Equipment (DME) - Rental or Purchase	80% coverage; subject to deductible	60% coverage; subject to deductible
Hearing Aid Not covered for individuals age eighteen (18) and older	80% coverage; subject to deductible	NO COVERAGE
Transplant Services	80% coverage; subject to deductible	NO COVERAGE
PHARMACY		
Tier 1 - Generic	50% up to $30 [1]	
Tier 2 - Preferred	50% up to $55 [1,2]	
Tier 3 - Non-Preferred	65% up to $80 [1,2]	
Tier 4 - Specialty	50% up to $80 [1,2]	
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	
Tier 2 - Preferred	$20 copay	
Tier 3 - Non-Preferred	$40 copay	
Tier 4 - Specialty	$40 copay	

[1] Prescription drug benefit - 31-day fill

For medications with a 32–62 day supply, the member copay would be 2 times the applicable tier copay.

For medications with a 63–93 day supply, the member copay would be 3 times the applicable tier copay.

[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).

NON-MEDICARE RETIREES
(RETIREMENT DATE BEFORE March 1, 2015)
Magnolia Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	MAGNOLIA LOCAL		MAGNOLIA LOCAL PLUS		MAGNOLIA OPEN ACCESS	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE						
EMPLOYEE ONLY	$0	NO COVERAGE	$0	NO COVERAGE	$300	
EMPLOYEE + 1	$0	NO COVERAGE	$0	NO COVERAGE	$600	
EMPLOYEE + 2 OR MORE	$0	NO COVERAGE	$0	NO COVERAGE	$900	
OUT-OF-POCKET MAXIMUM						
EMPLOYEE ONLY	$1,000	NO COVERAGE	$2,000	NO COVERAGE	$2,300	$4,300
EMPLOYEE + 1	$2,000	NO COVERAGE	$3,000	NO COVERAGE	$3,600	$7,600
EMPLOYEE + 2 OR MORE	$3,000	NO COVERAGE	$4,000	NO COVERAGE	$4,900	$10,900
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICIANS' SERVICES						
Preventative Care Primary Care Physician or Specialist Office or Clinic	100% coverage; not subject to deductible	NO COVERAGE	100% coverage; not subject to deductible	NO COVERAGE	100% coverage; not subject to deductible	70% coverage; subject to deductible
Primary Care Physician or Specialist Office - Treatment of illness or injury	100% coverage after a $25 PCP or $50 SPC copay per visit	NO COVERAGE	100% coverage after a $25 PCP or $50 SPC copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Maternity Care (prenatal, delivery and postpartum)	100% coverage; after a $90 copay per pregnancy	NO COVERAGE	100% coverage; after a $90 copay per pregnancy	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Physician Services Furnished in a Hospital Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist.	100% coverage; subject to deductible	NO COVERAGE	100% coverage; subject to deductible	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Physician Services for Emergency Room Care	100% coverage; subject to deductible	NO COVERAGE	100% coverage; subject to deductible	NO COVERAGE	90% coverage; subject to deductible	90% coverage; subject to deductible
Outpatient Surgery/ Services When billed as office visits	100% coverage; after a $25 PCP or $50 SPC copay per visit	NO COVERAGE	100% coverage; after a $25 PCP or $50 SPC copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Outpatient Surgery/ Services When billed as outpatient surgery at a facility	100% coverage; subject to deductible	NO COVERAGE	100% coverage; subject to deductible	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
HOSPITAL SERVICES						
Inpatient Services Inpatient care, delivery and inpatient short-term acute rehabilitation services	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	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible + $50 copay per day (days 1 - 50)

PCP = Primary Care Provider; SPC = Specialist

Non-Medicare Retirees
(RETIREMENT DATE BEFORE March 1, 2015)
Magnolia Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	MAGNOLIA LOCAL		MAGNOLIA LOCAL PLUS		MAGNOLIA OPEN ACCESS	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
HOSPITAL SERVICES						
Outpatient Surgery/ Services Hospital / Facility	100% coverage; after a $100 facility copay per visit	NO COVERAGE	100% coverage; after a $100 facility copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Emergency Room - Hospital (Facility) Treatment of an emergency medical condition or injury	100% coverage after $200 copay per visit; waived if admitted	NO COVERAGE	100% coverage after $200 copay per visit; waived if admitted	NO COVERAGE	90% coverage; subject to deductible; $200 copay per visit; waived if admitted	90% coverage; subject to deductible; $200 copay per visit; waived if admitted
BEHAVIORAL HEALTH						
Mental Health and Substance Abuse Inpatient Facility	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	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible + $50 copay per day (days 1-5)
Mental Health and Substance Abuse Outpatient Visits - Professional	100% coverage; after a $25 copay per visit	NO COVERAGE	100% coverage; after a $25 copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
OTHER COVERAGE						
Outpatient Acute Short-Term Rehabilitation Services Physical Therapy, Speech Therapy, Occupational Therapy, Other short term rehabilitative services	100% coverage; after a $25 copay per visit	NO COVERAGE	100% coverage; after a $25 copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Chiropractic Care	100% coverage; after a $25 copay per visit	NO COVERAGE	100% coverage; after a $25 copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Urgent Care Center	100% coverage after a $50 copay per visit	NO COVERAGE	100% coverage after a $50 copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Home Health Care Services	100% coverage subject to deductible	NO COVERAGE	100% coverage subject to deductible	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Skilled Nursing Facility Services	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	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Hospice Care	100% coverage subject to deductible	NO COVERAGE	100% coverage subject to deductible	NO COVERAGE	80% coverage; subject to deductible	70% coverage; subject to deductible

Non-Medicare Retirees
(RETIREMENT DATE BEFORE March 1, 2015)
Magnolia Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	MAGNOLIA LOCAL		MAGNOLIA LOCAL PLUS		MAGNOLIA OPEN ACCESS	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
OTHER COVERAGE						
Durable Medical Equipment (DME) - Rental or Purchase	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; subject to deductible; 100% in excess of $5,000 per plan year	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
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	90% coverage; subject to deductible	70% coverage; subject to deductible
Transplant Services	100% coverage; subject to deductible	NO COVERAGE	100% coverage; subject to deductible	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
PHARMACY						
Tier 1 - Generic	50% up to $30 [1]					
Tier 2 - Preferred	50% up to $55 [1,2]					
Tier 3 - Non-Preferred	65% up to $80 [1,2]					
Tier 4 - Specialty	50% up to $80 [1,2]					
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					
Tier 2 - Preferred	$20 copay					
Tier 3 - Non-Preferred	$40 copay					
Tier 4 - Specialty	$40 copay					

[1] Prescription drug benefit - 31-day fill

For medications with a 32–62 day supply, the member copay would be 2 times the applicable tier copay.

For medications with a 63–93 day supply, the member copay would be 3 times the applicable tier copay.

[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).

This comparison chart is a summary of plan features and is presented for general information only. It is not a guarantee of coverage.

NOTE: Prior Authorizations and Visit Limits may apply to some benefits - refer to your Plan Document for details.

NOTES

OFFICE OF GROUP BENEFITS

ogb

LOUISIANA







SUMMARY OF PLANS

Medicare Retirees

Medicare and Medicare Advantage

Important Information for Retirees: Annual Enrollment Periods for 2027

Annual Enrollment Opportunities

- Retirees have the opportunity to review and change their health plan during Annual Enrollment each year.

Medicare retirees who are enrolled in Medicare Parts A and B may choose to:

- Enroll in a Medicare Advantage plan, or
- Select an OGB secondary plan.

2027 Enrollment Deadlines

OGB Secondary Plans

- Medicare retirees have until November 15, 2026, to select an OGB secondary plan.

Medicare Advantage Plans

- Medicare retirees may enroll in a Medicare Advantage plan from October 15 through December 7, 2026.

Medicare Advantage Eligibility

- To enroll in a Medicare Advantage plan, all covered plan members must be enrolled in both Medicare Part A and B.

Important: Medicare Part D Coverage

- All OGB LA Blue Medicare plans include Medicare Part D prescription drug coverage.
- If you enroll in a separate Medicare Part D plan while enrolled in an OGB Blue Cross Medicare plan, you will be automatically disenrolled from your entire OGB plan, including medical coverage.

Be Cautious When Considering Medicare Advantage Plans

During Medicare Annual Enrollment, you may see television and radio advertisements or receive unsolicited phone calls or mail promoting Medicare Advantage plans.

Not all plans being advertised are sponsored by OGB. Before enrolling in or making changes to a Medicare Advantage plan, verify that the plan is an OGB-sponsored option. If you are unsure, contact OGB Customer Service before making a change.

Carefully review your options and enrollment deadlines to make sure you maintain the healthcare coverage that best meets your needs.

Inflation Reduction Act (IRA) of 2022

What is the Inflation Reduction Act (IRA) of 2022 and what does it mean for Medicare retirees?

The Inflation Reduction Act (IRA) brings significant changes to Medicare that aim to enhance the program's benefits and affordability for millions of people. Here's a breakdown of the key improvements:

- Expansion of Benefits: The IRA introduces new benefits and coverage options for Medicare recipients, ensuring they have access to a broader range of treatments and services.
- Lower Drug Costs: One of the major components of the IRA is the reduction in prescription drug costs. This includes measures to negotiate lower prices for certain high-cost medications and limit out-of-pocket expenses for beneficiaries.
- Stable Prescription Drug Premiums: The IRA includes provisions to keep prescription drug premiums stable, helping to prevent significant cost increases for Medicare recipients.
- Strengthening Medicare: The act is designed to improve the overall strength and sustainability of the Medicare program, ensuring that it can continue to provide essential services and support to beneficiaries in the future

Overall, the IRA aims to make Medicare more affordable and effective, providing crucial financial relief and access to care for its beneficiaries.

Key Benefits of the Inflation Reduction Act for Medicare Beneficiaries

- **Insulin Cost Cap:**
  $35 Per Month: Medicare beneficiaries will pay no more than $35 per month for each covered insulin prescription. This significant reduction aims to make insulin more affordable for those managing diabetes.
- **Access to Adult Vaccines Without Cost-Sharing:**
  Recommended adult vaccines will be available at no cost to OGB retirees enrolled in SilverScript Medicare Part D. This includes vaccines such as shingles, pneumococcal, and COVID-19 vaccines, helping ensure access to important preventive care without out-of-pocket costs.
- **Yearly Cap on Out-of-Pocket Prescription Drug Costs:**
  Starting in 2027, Medicare beneficiaries will have a cap of $2,000 on their out-of-pocket spending for prescription drugs. This cap provides financial protection and predictability for those with high medication costs.
- **Expansion of the Low-Income Subsidy Program (LIS or "Extra Help"):**
  The income threshold for the low-income subsidy program (also known as "Extra Help") will be expanded to cover individuals and families with incomes up to 150% of the federal poverty level. This expansion means more low-income beneficiaries will qualify for assistance with their Medicare Part D prescription drug plan costs, including premiums, deductibles, and co-pays.
- **The Medicare Prescription Payment Plan**
  The Medicare Prescription Payment Plan is a new payment plan that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments throughout the Plan year (January – December). **This payment plan might help you manage your expenses*, but it will not save you money or lower your drug costs.** "Extra Help" from Medicare, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members for whom Medicare pays primary are eligible to participate in the Medicare Prescription Payment Plan, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer the Medicare Prescription Payment Plan. Participation in the Medicare Prescription Payment Plan is completely optional. Visit Medicare.gov to learn more and find out if this payment plan is right for you. You will receive more information in the mail regarding this payment plan.

  *__Please Note:__ If a member fails to pay the monthly amount, their participation in the Medicare Prescription Payment Plan will be terminated and the member will revert to the usual cost sharing in place. The member will still owe the amount they failed to pay. Additionally, the member may be prevented from participating in the Medicare Prescription Payment Plan in the future.

For more information about the Inflation Reduction Act and how these changes will affect you, visit **www.medicare.gov.**

Medicare Advantage Backed by Blue!

Louisiana Blue has been a trusted protector of Louisianans' health since 1934. With Blue adVantage (HMO), you can access a comprehensive, local healthcare plan that combines medical, hospital and prescription drug coverage with additional benefits such as dental, vision, hearing, and fitness services — all in one convenient package.

Key features of Blue adVantage (HMO) include:

- **Comprehensive Coverage:** Integrated medical, hospital, and prescription drug coverage.
- **Additional Health Services:** Coverage for dental, vision, hearing, and fitness needs.
- **Prepaid Flex Card:** Use this card at participating retailers for eye wear and over-the-counter health-related products.
- **No-Cost Online Visits:** Free online primary care provider visits for easy access to care.
- **Member Rewards:** Earn rewards for completing select wellness activities.
- **Local Choice:** A plan designed to meet the needs of Louisiana residents with local support and services.

Medicare Plan Blue adVantage	
Covered Benefit	**Blue adVantage HMO**
Plan Year Deductible	$0
Maximum Out-of-pocket Expense (In-Network)	$2,000
Maximum Out-of-pocket Expense (Out-of-Network)	N/A
Office Visit - Primary Care / Specialist	$0/$20 copay per visit
Emergency Room	$50 ER copay per visit
Inpatient Hospital	$50 copay each day for days 1-10 and $0 copay each day for days 11-90
Prescription Drugs (Part D)	
Tier 1	$5 copay
Tier 2	$10 copay
Tier 3	$25 copay
Tier 4	$50 copay
Tier 5	20%
You may view the formulary at: blueadvantage.bcbsla.com/groups/pine	
Additional Benefits	
Hearing Aids	$0 copay for routine hearing exam $800 towards prescription hearing aids (once every 3 years)
Dental	$0 copay for preventive dental, includes 2 cleanings, 2 exams, 2 fluoride treatments and 1 x-ray; $2,200 maximum benefit for preventive and comprehensive dental per year
Eye-wear	$300 allowance for glasses or contact lenses per year
Over-the-Counter (OTC) Allowance	$50 per quarter OTC benefit for health-related products
On-line Primary Care Provider Visits	$0 copay for qualifying online provider visits

Medicare Plan through Humana

Humana is excited to present the benefits available for 2026! When selecting an OGB-sponsored plan, make sure to compare benefits and rates to find the option that best suits your needs. Humana's HMO service area covers all parishes in Louisiana, ensuring comprehensive local coverage.

Key Features of Humana's 2027 HMO Plan:

- **Statewide Coverage:** Available across all parishes in Louisiana.
- **Comprehensive Benefits:** Inclusive coverage for medical, hospital, and prescription drug needs.
- **Additional Services:** Includes dental, vision, hearing, and wellness programs.

For more detailed information or to get your questions answered:

Call Humana: 877-889-9885 (TTY: 711), Monday to Friday, 7 am – 8 pm CT

Medicare Plan through Humana	
Covered Benefit	**Humana Medicare Advantage Employer HMO Plan**
Plan Year Deductible	$0
Maximum Out-of-pocket Expense	$2,000
Office Visit Primary Care / Specialist	$0 / $10 copay per visit
Emergency Room	$50 Copay; waived if admitted within 24 hours
Inpatient Hospital	$50 Copay per day (days 1-10)
Prescription Drugs (Part D) - $2,400 out-of-pocket maximum on prescription drugs	
Tier 1 - Preferred Generics and Generics	$0
Tier 2 - Preferred Brand	$20
Tier 3 - Non-Preferred Brand	$40
Tier 4 - Specialty	20%
You may view or request a formulary at: Humana.com or call Humana: 877-889-9885 (TTY: 711)	
Additional Benefits	
Transportation	$0 copayment Post-Discharge Transportation. For plan approved location up to 12 one-way trip(s) per facility discharge by car, van, wheelchair access vehicle. Benefit not to exceed 50 miles per trip.
Routine Hearing Exam	$25 copay for fitting/evaluation, routine hearing exams up to 1 per year. $2,000 maximum benefit coverage for hearing aids up to 2, every 3 years
Routine Vision	100% for routine exam, up to 1 per year
Meals After Inpatient Stay	28 meals available post-discharge
Routine Dental	$500 maximum benefit coverage amount per year for all preventive and comprehensive benefits.
Silver Sneakers	A total health and physical activity program included in your plan at no extra cost. www.silversneakers.com

Medicare Plan through Peoples Health

The Peoples Health plan for Office of Group Benefits offers all the benefits covered by Medicare, plus additional benefits like:

- Part D Rx drug coverage with $0 tier 1 & tier 2 generics
- Complimentary fitness center membership
- Respite care for members diagnosed with dementia
- Routine dental, hearing and vision care
- $0 meals after eligible hospital stays

Founded in Louisiana, Peoples Health offers coordinated and personalized service tailored to your needs. Peoples

Medicare Plan through Peoples Health	
Covered Benefit	**Peoples Health HMO-POS**
Plan Year Deductible	$0
Maximum Out-of-pocket Expense (In-Network)	$2,500 for Medicare-covered Part A and Part B services
Maximum Out-of-pocket Expense (Out-of-Network)	There is no out-of-network maximum. Out-of-network services do not count towards the in-network maximum.
Office Visit - Primary Care / Specialist	$0 copay per visit with network primary care provider; $10 copay per visit with network specialist; referrals are required for in-network specialist physician services; 20% coinsurance per visit with out-of-network providers
Emergency Room	$50 copay per visit, including for worldwide emergency services
Inpatient Hospital	$50 copay per day (days 1-10) with network providers; Medicare-defined cost-sharing with out-of-network providers, (released by Medicare in October 2026)
Prescription Drugs (Part D)	
Tier 1	$0 copay
Tier 2	$0 copay
Tier 3	$20 copay (30-day supply)
Tier 4	$40 copay (30-day supply)
Tier 5	20% coinsurance
You may view the Peoples Health list of covered drugs at **peopleshealth.com**	
Additional Benefits	
Preventive Dental	$0 copay for oral exams, cleanings, and X-rays from network providers; coverage frequency varies. Out-of-network services may have higher costs.
Comprehensive Dental	$0 copay - 50% coinsurance for comprehensive services from network providers; coverage frequency varies by service. Covered up to $2,000 per year for comprehensive and preventive services. Out-of-network dental services may have higher costs
Diagnostic Hearing Exam	$10 copay for each Medicare-covered diagnostic hearing exam and $0 copay for each routine hearing exam from network providers; 20% coinsurance for each Medicare-covered exam from out-of-network providers.
Meal Benefit	$0 copay for home-delivered meals from the network meal provider after an eligible hospital stay. Restrictions apply.
Respite Care	$0 copay for each session with the network respite care provider, up to 12 sessions every year. This benefit is for members diagnosed with dementia. Restrictions apply.
Eye-wear	$0 copay for one pair of standard lenses for routine correction each year from network providers; plan pays up to $200 every year for frames or contact lenses from network providers.

Via Benefits: Tailor Your Insurance to Fit Your Needs

Willis Towers Watson's Via Benefits is a personalized Medicare Exchange designed for OGB retirees and their spouses who have Medicare Parts A and B. This platform provides a wide range of medical, prescription drug, and dental plans tailored to your provider preferences, prescription needs, location, and medical conditions. Options include Medicare Advantage, Medicare Supplement (Medigap), and Medicare Part D Prescription Drug coverage.

Expert Advice and Enrollment Support

Via Benefits offers access to licensed benefit advisors and online tools with extensive knowledge of the Medicare market. Advisors are available to assist you throughout the enrollment process and beyond. Contact them at (855) 663-4228, Monday through Friday, from 8:00 a.m. to 8:00 p.m. Central Time.

Eligibility

To qualify for Via Benefits, you must be an OGB retiree with Medicare Parts A and B. The service provides personalized help to ensure you choose the health plan that best meets your needs and budget.

Health Reimbursement Arrangement (HRA)

If you enroll in a medical plan through Via Benefits, you'll receive a Health Reimbursement Arrangement (HRA). This tax-free account allows you to be reimbursed for qualified medical expenses such as copayments, deductibles, coinsurance, and premiums, including Medicare B premiums. A single retiree receives $200 per month, while a retiree with a spouse gets $300 per month in HRA credits from the agency they retired from. The annual reimbursement limit is $2,400 for member only coverage and $3,600 member plus dependent coverage. Any unused funds can be rolled over into the next plan year. If a member ends participate in the plan any unused funds will be forfeited.

Plan Comparison Tools

Via Benefits provides various tools to help you compare insurance plans and premiums, including the Prescription Profiler™. This tool assesses your current and future medication costs to help you find plans with the lowest estimated annual out-of-pocket expenses.

For More Information

Call Via Benefits at (855) 663-4228 between 8:00 a.m. and 8:00 p.m. Central Time, Monday through Friday, or visit the online plan comparison tool at **my.ViaBenefits.com/ogb.**

Sampling of Plans Available through Via Benefits

UNITED VISION PLAN UVP

wellcare

AARP | Medicare Supplement from UnitedHealthcare

LOUISIANA BLUE

PEOPLES HEALTH A UnitedHealthcare Company

vsp individual vision plans

MetLife

cigna healthcare

Humana

Guardian

Renaissance Dental

For a complete list of plans and providers visit: my.ViaBenefits.com/ogb

Or call Via Benefits at 1-855-663-4228.

Pelican HRA1000

The Pelican HRA1000 plan is designed to provide financial support for your healthcare expenses through a health reimbursement account (HRA). Here are the key features of this plan:

- **Annual Employer Contributions:** Receive $1,000 for employee-only plans and $2,000 for employee plus dependent(s) plans deposited into your HRA each year.
- **Offset Healthcare Costs:** Use these funds to help cover your deductible and other out-of-pocket healthcare expenses throughout the year.
- **Rollover Benefits:** Any unused funds in your HRA will roll over to the next plan year, up to the In-Network out-of-pocket maximum, as long as you stay enrolled in the Pelican HRA1000 plan. This allows you to accumulate funds for future medical expenses. Funds are forfeited when you leave the HRA plan or the plan is no longer offered.

The Pelican HRA1000 plan offers a practical way to manage and reduce your healthcare costs with the added benefit of building a financial cushion for future medical needs.

Medicare Retirees (when Medicare is primary payer ONE participant)		
	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLES		
Retiree Only	$2,000	$4,000
Family	$4,000	$8,000
OUT-OF-POCKET MAXIMUMS		
Medical Out-of-pocket max (applies to each covered person)**		
Retiree Only	$3,000	$10,000
Family	$8,000	$20,000
Prescription Out-of-pocket max (applies to each covered person when Medicare pays primary)		
Each Covered Person	$2,000	
Medicare Retirees (when Medicare is primary payer for TWO participants)		
OUT-OF-POCKET MAXIMUMS		
Medical Out-of-pocket max (applies to each covered person)**		
Family	$6,000	$20,000
Prescription Out-of-pocket max (applies to each covered person when Medicare pays primary)		
Each Covered Person	$2,000	
Medicare Retirees (when Medicare is primary payer for THREE participants)		
OUT-OF-POCKET MAXIMUMS		
Medical Out-of-pocket max (applies to each covered person)**		
Family	$4,000	$20,000
Prescription Out-of-pocket max (applies to each covered person when Medicare pays primary)		
Each Covered Person	$2,000	
COINSURANCE (Once deductible has been met)		
Each Covered Person	20%	40%

See page 50 for information on pharmacy benefits for this plan.

Magnolia Local Plus (Nationwide In-Network Providers)

The Magnolia Local Plus plan offers comprehensive coverage with a focus on predictability and access to a broad network of providers. Here are the key features:

- **Nationwide In-Network Providers:** Access an extensive network of In-Network providers across the country.
- **Predictable Costs:** Enjoy the consistency of copays for healthcare services instead of relying on employer funding to cover out-of-pocket expenses.
- **Emergency Coverage:** Out-of-Network care is covered only in emergencies, with the possibility of balance billing for any costs not covered by the insurance.
-

Medicare Retirees (when Medicare is primary payer ONE participant)				
	Retirees ON or AFTER 3/1/2015		Retirees BEFORE 3/1/2015	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLES				
Retiree Only	$400	No Coverage	$0	No Coverage
Retiree + 1	$800	No Coverage	$0	No Coverage
Retiree + 2 or more	$1,200	No Coverage	$0	No Coverage
OUT-OF-POCKET MAXIMUMS				
Medical Out-of-pocket max (applies to each covered person)**				
Retiree Only	$1,500	No Coverage	$500	No Coverage
Retiree + 1	$4,000	No Coverage	$1,500	No Coverage
Retiree + 2 or more	$6,500	No Coverage	$2,500	No Coverage
Prescription Out-of-pocket max (applies to each covered person when Medicare pays primary)				
Each Covered Person	$2,000		$1,500	
Medicare Retirees (when Medicare is primary payer for TWO participants)				
OUT-OF-POCKET MAXIMUMS				
Medical Out-of-pocket max (applies to each covered person)**				
Retiree + 1	$2,000	No Coverage	$0	No Coverage
Retiree + 2 or more	$4,000	No Coverage	$1,000	No Coverage
Prescription Out-of-pocket max (applies to each covered person when Medicare pays primary)				
Each Covered Person	$2,000		$1,500	
Medicare Retirees (when Medicare is primary payer for THREE participants)				
OUT-OF-POCKET MAXIMUMS				
Medical Out-of-pocket max (applies to each covered person)**				
Retiree + 2 or more	$2,500	No Coverage	$0	No Coverage
Prescription Out-of-pocket max (applies to each covered person when Medicare pays primary)				
Each Covered Person	$2,000		$1,500	
COPAYS				
Primary Care Physician (PCP)	$25	No Coverage	$25	No Coverage
Specialist (SPC)	$50	No Coverage	$50	No Coverage

See page 50 for information on pharmacy benefits for this plan.

Magnolia Open Access (Nationwide Providers)

The Magnolia Open Access Plan offers flexible coverage with both In-Network and Out-of-Network options. Here's a summary of its features:

- **Nationwide Coverage:** Access to a nationwide network of providers, offering flexibility for members who live out of state or travel frequently.
- **Cost Structure:** Instead of copays, you pay a percentage of costs after meeting your deductible:
  - **In-Network Care:** Pay 10% of the allowable amount after meeting the deductible.
  - **Out-of-Network Care**: Pay 30% of the allowable amount after meeting the deductible, with the potential for balance billing.

Medicare Retirees (when Medicare is primary payer ONE participant)					
	Retirees ON or AFTER 3/1/2015 With or Without Medicare		Retirees BEFORE 3/1/2015 Without Medicare		Retirees BEFORE 3/1/2015 With Medicare
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK & OUT-OF-NETWORK
DEDUCTIBLES					
Retiree Only	$900	$900	$300		$300
Retiree + 1	$1,800	$1,800	$600		$300
Retiree + 2 or more	$2,700	$2,700	$900		$300
OUT-OF-POCKET MAXIMUMS					
Medical Out-of-pocket max (applies to each covered person)**					
Retiree Only	$1,500	$4,700	$2,300***	$4,300***	$1,300
Retiree + 1	$4,000	$8,500	$1,600	$7,600	$3,600
Retiree + 2 or more	$6,500	$12,250	$2,900	$10,900	$5,900
Prescription Out-of-pocket max (applies to each covered person when Medicare pays primary)					
Each Covered Person	$2,000		$2,000		$2,000
Medicare Retirees (when Medicare is primary payer for TWO participants)					
OUT-OF-POCKET MAXIMUMS					
Medical Out-of-pocket max (applies to each covered person)**					
Retiree + 1	$2,000	$8,500	Not Applicable	Not Applicable	$1,600
Retiree + 2 or more	$4,500	$12,250	$900	$10,900	$3,900
Prescription Out-of-pocket max (applies to each covered person when Medicare pays primary)					
Each Covered Person	$2,000		$2,000		$2,000
Medicare Retirees (when Medicare is primary payer for THREE participants)					
OUT-OF-POCKET MAXIMUMS					
Medical Out-of-pocket max (applies to each covered person)**					
Retiree + 2 or more	$2,500	$12,250	$0	$10,900	$1,900
Prescription Out-of-pocket max (applies to each covered person when Medicare pays primary)					
Each Covered Person	$2,000		$2,000		$2,000
COINSURANCE (Once deductible has been met)					
Each Covered Person	20%	20%	20%	20%	20%	20%

See page 50 for information on pharmacy benefits for this plan.

We encourage you to make sure you choose a doctor or hospital in your provider network when you need healthcare. By choosing a network provider, you avoid the possibility of having your provider bill you for amounts in addition to applicable copays, coinsurance, deductibles and non-covered services.

Retiree 100 Program Overview:

The Retiree 100 program is designed to provide supplemental coverage for retired members and/or spouses enrolled in the Magnolia Open Access plan who have Medicare Part A and Part B as their primary insurer. Here are the key details:

Coverage Purpose:

- **Supplemental Coverage:** Retiree 100 serves as additional coverage for members facing extensive hospital bills or large physician charges due to serious illness, accidents, or long-term chronic conditions.

Eligibility and Coverage:

- **Eligible Expenses:** Retiree 100 coordinates expenses eligible for reimbursement by both Medicare and the Magnolia Open Access plan. It does not include coverage for prescription drugs.
- **Premiums:** The monthly premium for Retiree 100 is $81.00 per person, paid in addition to your monthly OGB premium. There is no state contribution towards the premium; the entire cost must be covered by the member.
- **Enrollment:** Retired members can enroll during the annual enrollment period held each year or within 30 days after becoming eligible for Medicare (Parts A and B). Coverage becomes effective on the first day of the month the member became eligible for Medicare.

Important Considerations:

- Retiree 100 is designed to provide additional financial support for significant medical expenses not fully covered by Medicare and the Magnolia Open Access plan.
- It's crucial to assess your healthcare needs and financial situation to determine if Retiree 100 is the right choice for you.

Enrollment documents are available on the OGB website, ogb.la.gov.

***Medical Out-of-Pocket Maximum applies to medical expenditures for all Plan Participants and to Prescription expenditures for Plan Participants when OGB is the primary payer. Prescription Out-of-Pocket Maximum applies to each Plan Participant when Medicare is the primary payer.*

****Separate Prescription Out-Of-Pocket Maximum does not apply to retirees without Medicare.*

Magnolia Local (Select, In-Network Provider Only Plan)

The Magnolia Local plan is a select, In-Network provider only plan for members who live in specific coverage areas. Magnolia Local is a health plan for members who want local access, affordable premiums and a new approach to healthcare.

Out-of-Network care is covered only in emergencies and the member may be balance-billed.

What is different about Magnolia Local?

- **Your network of doctors and hospitals is more limited in service area** than other plans. You still have a full network of primary care doctors, specialists and other healthcare providers in your area.
- **You have a coordinated care team** that talks to one another and helps you get the right care in the right place.
- **Staying in network is very important!**
- Where you live will determine which Magnolia Local network you will use.

Before you choose Magnolia Local, consider this:

- Which doctors/clinics do you go to the most?
- Which clinics/hospitals are closest to where you live?
- Staying in network is very important! As long as you receive care within your network, you will pay less than if you receive care outside of the network.

Magnolia Local has two networks: Community Blue & Blue Connect

Community Blue is a select, local network designed ***only*** for members who live in the parishes of **Ascension, East Baton Rouge, Livingston, and West Baton Rouge**.

Blue Connect is a select, local network designed ***only*** for members who live in the parishes of **Acadia, Bossier, Caddo, Evangeline, Iberia, Jefferson, Lafayette, Orleans, Plaquemines, St. Bernard, St. Charles, St. James, St. John the Baptist, St. Landry, St. Martin, St. Mary, St. Tammany, Terrebonne, and Vermilion.**

Community Blue* (for residents in the Baton Rouge Region)

You have access to many healthcare providers in following regions:

Baton Rouge Region

- Baton Rouge General Medical Center
- The Baton Rouge Clinic*
- BR General Physicians Group
- Ochsner Medical Center Baton Rouge
- Ochsner Clinic
- Ochsner The Grove

To find a complete list of providers in this network, visit **lablue.com/ogb** and choose your member type under Magnolia Local. Click Find a Doctor, then Find a Community Blue Doctor.

* Select physicians available at The Baton Rouge Clinic. Does not include gastroenterologist physicians.

Blue Connect* (for residents in the New Orleans, Bayou, Lafayette, Northshore and Shreveport/Bossier Regions)

You have access to the many healthcare providers in the following regions:

Greater New Orleans Region/Bayou Regions

- Ochsner Health System and its affiliates
- Terrebonne General Medical Center
- Leonard J. Chabert Medical Center

Lafayette Region

- Ochsner Lafayette General and its affiliates
- Opelousas General Health System
- Ochsner Abrom Kaplan Memorial Hospital
- Abbeville General Hospital
- Iberia Medical Center

St. Tammany Region

- Ochsner Medical Center Northshore
- St. Tammany Health System
- Slidell Memorial Hospital

Shreveport/Bossier Region

- CHRISTUS Shreveport-Bossier Health System and its affiliates
- Ochsner LSU Health Shreveport and its affiliates

To find a complete list of providers in this network, visit **lablue.com/ogb** and choose member type under Magnolia Local. Click Find a Doctor, then Find a Blue Connect Doctor.

*Providers in the Community Blue and Blue Connect networks are subject to change. View Louisiana Blue's network providers at **lablue.com/ogb.***

IMPORTANT! Magnolia Local is a perfect fit for some, but not others. We encourage you to carefully review the doctors/clinics/hospitals within the Community Blue and Blue Connect networks before selecting this option.

Medicare Retirees (when Medicare is primary payer ONE participant)				
	Retirees ON or AFTER 3/1/2015		Retirees BEFORE 3/1/2015	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLES				
Retiree Only	$400	No Coverage	$0	No Coverage
Retiree + 1	$800	No Coverage	$0	No Coverage
Retiree + 2 or more	$1,200	No Coverage	$0	No Coverage
OUT-OF-POCKET MAXIMUMS				
Medical Out-of-pocket max (applies to each covered person)**				
Retiree Only	$500	No Coverage	$0	No Coverage
Retiree + 1	$3,000	No Coverage	$1,000	No Coverage
Retiree + 2 or more	$5,500	No Coverage	$2,000	No Coverage
Prescription Out-of-pocket max (applies to each covered person when Medicare pays primary)				
Each Covered Person	$2,000		$1,000	
Medicare Retirees (when Medicare is primary payer for TWO participants)				
OUT-OF-POCKET MAXIMUMS				
Medical Out-of-pocket max (applies to each covered person)				
Retiree + 1	$1,000	No Coverage	$0	No Coverage
Retiree + 2 or more	$3,500	No Coverage	$1,000	No Coverage
Prescription Out-of-pocket max (applies to each covered person when Medicare pays primary)				
Each Covered Person	$2,000		$1,000	
Medicare Retirees (when Medicare is primary payer for THREE participants)				
OUT-OF-POCKET MAXIMUMS				
Medical Out-of-pocket max (applies to each covered person)				
Retiree + 2 or more	$1,500	No Coverage	$0	No Coverage
Prescription Out-of-pocket max (applies to each covered person when Medicare pays primary)				
Each Covered Person	$2,000		$1,000	
COPAYS				
Primary Care Physician (PCP)	$25	No Coverage	$25	No Coverage
Specialist (SPC)	$50	No Coverage	$50	No Coverage

See page 50 for information on pharmacy benefits for this plan.

SilverScript®

SilverScript Employer PDP sponsored by State of Louisiana Office of Group Benefits (SilverScript)

SilverScript® Insurance Company and the Office of Group Benefits have teamed up to provide you with a Medicare Part D prescription drug benefit.

2026 SilverScript Plan Design for OGB Retirees			
Annual Out-of-Pocket Threshold	$1,500		
Prescription Benefit Tier	**Network Retail Pharmacy** (31-day supply)	**Network Retail Pharmacy** (93-day supply)	**Mail Service Pharmacy[1]** (93-day supply)
Before $1,500 out-of-pocket threshold is met:			
Generic Drugs	50% coinsurance $30 maximum	50% coinsurance $75 maximum	50% coinsurance $75 maximum
Preferred Brand Drugs	50% coinsurance $55 maximum	50% coinsurance $137.50 maximum	50% coinsurance $137.50 maximum
Non-Preferred Brand Drugs	65% coinsurance $80 maximum	65% coinsurance $200 maximum	65% coinsurance $200 maximum
Specialty Drugs	50% coinsurance $80 maximum	Not Available	50% coinsurance $80 maximum Limited to 31 days
After you reach $1,500 out-of-pocket threshold:			
Generic Drugs	$0	$0	$0
Preferred Brand Drugs	$20	$50	$50
Non-Preferred Brand Drugs	$40	$100	$100
Specialty Drugs	$40	Not Available	$40 Limited to 31 days
Catastrophic Coverage	Once your Medicare out-of-pocket costs reach $2,100 for the year, you move to the Catastrophic Coverage stage. During the Catastrophic Coverage stage, **you will have $0 copayment for all covered drugs for the remainder of the year.**		
You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier. After you reach your OGB annual drug out-of-pocket maximum, you will pay $0 copayment for your covered prescription drugs for the rest of the plan year.			
More info can be found at https://info.caremark.com/oe/ogbmedicarerx			

Get Coverage Wherever You Go!

There are more than 65,000 pharmacies nationwide in our pharmacy network. **There are pharmacies other than CVS Pharmacy®, including over 600 independent Louisiana pharmacies and approximately 550 chain pharmacies, such as Albertson's, Brookshire, Walgreens, Super 1 Pharmacy, Winn-Dixie and more.**

You must use a network pharmacy in order to receive full benefit coverage on your prescriptions. Call SilverScript Customer Care at 1-888-996-0104 to find a retail pharmacy near your home or where you are traveling in the United States or U.S. territories, or if you want information about the mail service pharmacy[1]. TTY users should call 711.

Savings. Safety. Service.

We are committed to helping you get the most out of your SilverScript plan—and that means providing you with information that will save you money on your prescription drugs.

Questions?

Your satisfaction is important to us. If you have any questions about your SilverScript prescription drug benefit, please call **SilverScript Customer Care** at **1-888-996-0104**, 24 hours a day, 7 days a week. TTY users should call 711. Visit our website at https://info.caremark.com/oe/ogbmedicarerx for general plan-related information.

You can receive your Explanation of Benefits (EOB) Online!

Opt in to go paperless and you will receive an email when your new statement is ready to view, instead of receiving a paper copy in the mail.

- View up to 36 months of your EOBs, organized by date in one location
- Reduce clutter by downloading and printing only the statements you need
- Keep your prescription information secure – no shredding necessary

To get started, visit Caremark.com to register and set your account profile preferences to paperless EOB's. You can opt out at any time.

If you have dual coverage and have questions as to how Medicare Part D coordinates with other benefits, contact SilverScript Customer Care.

SilverScript Employer PDP is a Prescription Drug Plan. This plan is offered by SilverScript Insurance Company, which has a Medicare contract. Enrollment depends on contract renewal.

[1]The typical number of business days after the mail order pharmacy receives an order to receive your shipment is up to 10 days. Enrollees have the option to sign up for automated mail order delivery.

SilverScript Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Formulary and/or Pharmacy network may change at any time. You will receive notice when necessary. Your privacy is important to us. SilverScript employees are trained regarding the appropriate way to handle your private health information.

How to Enroll

All Medicare Retirees

There are three ways to change a health plan. Choose one that works best for you:

1. Online Enrollment Portal:

- Visit OGB's annual enrollment web portal at ogb.la.gov.
- Log in using your insurance cards and identification numbers, such as your date of birth and Social Security number.
- Follow the prompts to change or update your health plan selections.

This method is convenient for those who prefer to manage their enrollment online.

2. Annual Enrollment Form:

- Complete the annual enrollment form provided by OGB (found on page 51 of the enrollment materials).
- Ensure all required information is filled out accurately.
- Return the form to the address provided by the specified deadline, which is November 15.

This option is suitable for those who prefer to submit physical paperwork.

3. Written Letter Submission:

- Draft a dated and signed letter to OGB detailing the changes or updates you wish to make to your health plan.
- Include your Social Security number and any new dependent information, such as name, birth date, and Social Security number.
- Attach any necessary dependent verification documentation, such as marriage or birth certificates.
- Submit the letter via mail, email, or fax to the Office of Group Benefits using the following contact details:
    - Mail to: Office of Group Benefits, Annual Enrollment, P.O. Box 44036, Baton Rouge, LA 70804
    - Email to: OGB.CustomerService@la.gov
    - Fax to: (225) 342-9917 or (225) 342-9919

This method offers flexibility for those who prefer written communication.

Please note: If you choose to discontinue your OGB coverage entirely, it's important to understand that you may not be able to reinstate it in the future.

IMPORTANT! If you would like to remain in your current OGB health plan with the same covered dependents for the 2027 Plan Year, you do not need to do anything. Your coverage will continue for the 2027 Plan Year.

OFFICE OF GROUP BENEFITS

2027 ANNUAL ENROLLMENT FORM

Retirees with Medicare

(Please PRINT Clearly)

Plan Member's Name: _____

Address: _____

City, State, ZIP: _____

SSN: _____ **Phone:** (_____) _____

Personal email address: _____

NO ACTION IS NECESSARY IF YOU DO NOT WISH TO MAKE A CHANGE.

IF YOU WISH TO MAKE A CHANGE, PLEASE MARK ONE AND ONLY ONE SELECTION

BY PLACING AN (X) IN THE APPROPRIATE BOX

OGB Secondary Plans for Retirees with Medicare

☐ R **Pelican HRA1000**
Administered by LA Blue

☐ P **Magnolia Local Plus**
Administered by LA Blue

☐ A **Magnolia Open Access**
Administered by LA Blue

☐ L **Magnolia Local**
(Limited In-Network Provider Network)
Administered by LA Blue

OGB Sponsored Medicare Advantage Plans

☐ C **Blue adVantage Medicare Advantage HMO Plan**
Retiree and all covered dependents must have both Medicare A and Medicare B

☐ G **Humana HMO Medicare Advantage Plan**
Retiree and all covered dependents must have both Medicare A and Medicare B

☐ T **Peoples Health Medicare Advantage HMO Plan**
Retiree and all covered dependents must have both Medicare A and Medicare B

Via Benefits*
Retiree and all covered dependents must have both Medicare A and Medicare B
(***Enrollment is conducted through Via Benefits. Please call 1-855-663-4228 or visit my.ViaBenefits.com/ogb** to enroll.)

PLEASE MAIL OR FAX THIS FORM TO OGB BY NOVEMBER 15, 2026.

By Mail: Office of Group Benefits
Annual Enrollment
P.O. Box 44036
Baton Rouge, LA 70804

By Email: OGB.CustomerService@la.gov

By Fax: Office of Group Benefits
Annual Enrollment
(225) 342-9917
or
(225) 342-9919

_____ _____

Plan Member's Signature *(required)* **Date**

CUT ALONG DOTTED LINES

How to Read Your Benefits Comparison

Your Benefits Comparison has 3 main sections:

1

Cost Comparison

A comparison of the different Copays, Coinsurance, and Deductibles across offered plans. A Copay is a fixed payment for a covered service, and does not count toward your Deductible. A Coinsurance is the amount you pay for certain services after you have met your deductible. A Deductible is the amount you pay annually before your insurance begins to pay.

2

Out-of-Pocket Comparison

A comparison of the different Out-of-Pocket Maximums across offered plans. An Out-of-Pocket Maximum is the most you'll have to pay annually for health care services. Deductibles, Copays, Coinsurance and other medical expenses count toward your Out-of-Pocket Maximum. Your monthly premium does not.

3

Plan Benefits Summary

A high-level comparison of the benefits offered across each plan. Use to compare the different Copays, Coinsurance and Deductibles you may be responsible for when using different medical and pharmacy benefits. **This comparison chart is a summary of plan features and is presented for general information only. For a complete list of plan features, please review the plan documents posted on-line at ogb.la.gov**.

NOTE: This section also breaks down plans for Medicare Advantage, plans for retirees with Medicare (retirement date before March 1, 2015), and plans for retirees with Medicare (retirement date ON or AFTER March 1, 2015)

Choose a Plan Structure and Network: Some plan types allow you to use almost any doctor or health care facility. Others limit your choices, have no out-of-network coverage or charge you more if you use providers outside the network.

Compare Out-of-Pocket Costs

You may want a plan with low out-of-pocket costs if:

- You see a doctor, such as a specialist, on a regular basis
- You frequently need emergency care
- You take expensive or brand-name medications on a regular basis
- You have a planned surgery coming up
- You've recently been diagnosed with a chronic condition such as diabetes or cancer

You may want a plan with higher out-of-pocket costs if:

- You cannot afford a plan with lower out-of-pocket costs
- You are in good health and rarely see a doctor
- You rarely participate in activities with a high risk of injury

Compare Covered Benefits

- Compare the Copay, Coinsurance and Deductible of any planned services or procedures for the upcoming plan year.
- See if your physician or preferred facility is covered under each plan by visiting lablue.com
- Review your prescription cost across plans by searching the formularies for each plan. If you are on maintenance medications, consider mail order to reduce costs.

Medicare Advantage HMO Plans
Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

	Blue adVantage (HMO)	Humana Medicare Advantage Employer HMO	Peoples Health HMO-POS
	Network	Network	Network *Some services are covered out-of- network. Out-of-network costs vary.*
	You Pay	**You Pay**	**You Pay**
Deductible			
RETIREE	$0	$0	$0
RETIREE + 1	$0	$0	$0
Out-of-Pocket Maximum			
RETIREE RETIREE + 1	$2,000 per member	$2,000 per member	$2,500 per member for Medicare-covered Part A and Part B services
Physicians' Services	**The Plan Pays**		
Primary Care Physician or Specialist Office Visit- Treatment of illness or injury	100% coverage after a $0 PCP copay or $20 SPC copay	PCP -100% after $0 Copay Specialist - 100% after $10 Copay	100% coverage after $0 PCP or $10 specialist copay per visit; referrals are required for in-network specialist physician services
Medicare A & B Covered Preventative Care in a 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	100% coverage	100% coverage
Physician Services for Emergency Room Care	100% coverage	100% coverage	100% coverage
Allergy Shots and Serum	100% coverage after $0 copay	PCP -100% after $0 Copay Specialist - 100% after $10 Copay	95% coverage
Outpatient Surgery/Services when billed as office visits	100% coverage	PCP - 100% after $0 Copay Specialist - 100% after $10 Copay	100% coverage after $0 PCP copay per visit; 100% coverage after $10 specialist copay per visit
Inpatient Services Inpatient care, delivery and inpatient short-term acute rehabilitation services	$50 copay each day for days 1-10 and $0 copay each day for days 11-90	100% after $50 copay per day (days 1 - 10)	100% coverage after $50 copay per day (days 1-10)
Outpatient Surgery/Services Hospital/Facility	100% coverage	100% coverage	100% coverage
Emergency Room Care - Hospital Treatment of an emergency medical condition or injury	100% coverage after $50 copay; waived if admitted	100% after $50 copay; waived if admitted within 24 hours	100% coverage after $50 copay per visit; waived if admitted within 24 hours
Behavioral Health	**The Plan Pays**		
Mental Health and Substance Abuse Inpatient Facility	100% after $25 copay days 1-5	100% after $25 copay per day (days 1 - 5); 190 day lifetime limit in a psychiatric facility	100% coverage after $25 copay per day (days 1-5)
Mental Health and Substance Abuse Outpatient Visits - Professional	100% coverage after mental health outpatient $10 copay / substance abuse outpatient $20 copay	100% coverage	100% coverage

Medicare Advantage HMO Plans
Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

	Blue adVantage (HMO)	Humana Medicare Advantage Employer HMO	Peoples Health HMO-POS
	Network	Network	Network *Some services are covered out-of- network. Out-of-network costs vary.*
Other Coverage	**The Plan Pays**		
Outpatient Acute Short-Term Rehabilitation Services Physical Therapy, Speech Therapy, Occupational Therapy, Other short term rehabilitative services	100% coverage	100% coverage	100% coverage
Chiropractic Care	100% coverage after $20 copay	100% after $10 copay (Medicare Covered)	100% coverage after $10 copay per visit
Vision Exam (routine)	100% coverage; one exam per year	100% coverage; one exam per year.	100% coverage; 1 exam per year
Urgent Care Center	100% coverage after $10 copay	100% coverage after $10 copay per visit	100% coverage after $5 copay per visit
Home Health Care Services	100% coverage	100% (Excludes Personal Home Care)	100% coverage
Skilled Nursing Facility Services	100% coverage after $0 copay for days 1-20 and $25 for days 21-100	100% per day (days 1 - 20); $25 copay per day (days 21 - 100)	100% coverage days 1-20 100% coverage after $25 copay per day, days 21+
Hospice Care	Covered by Medicare	Covered by Medicare	Covered by Medicare
Durable Medical Equipment (DME) –Rental or Purchase	95% coverage	DME Provider - 95% coverage Pharmacy - 100% coverage	95% coverage
Transplant Services	100% coverage after $50 copay per day (days 1-10)	See Inpatient Services; requires prior authorization	100% coverage after $50 copay per day (days 1-10) for the inpatient stay associated with the transplant
Pharmacy	**You Pay**		
Tier 1 - Preferred Generic	$5(3 months)	$0 copay ***(Generic/Preferred Generic)***	$0 copay
Tier 2 - Generic	$10 (3 months)	$20 copay ***(Preferred Brand)***	$0 copay
Tier 3 - Preferred Brand	$25 (3 months)	$40 copay ***(Non-Preferred Brand)***	$20 copay (30-day supply)
Tier 4 - Non-Preferred Drug	$50 (3 months)	20% coinsurance ***(Specialty)*** Limited to 30-day supply	$40 copay (30-day supply)
Tier 5 - Specialty Tier	20% coinsurance	N/A	20% coinsurance

This comparison chart is a summary of plan features and is presented for general information only. It is not a guarantee of coverage.

The benefits outlined in this document were provided by HMO Louisiana (Blue Advantage), Humana, and Peoples Health; OGB is not responsible for the accuracy of this information.

NOTE: Prior authorizations, visit limits and age and/or time restrictions may apply to some benefits - refer to your official plan document for details.
All services are subject to the terms of the Plan document.

Medicare Retirees
(RETIREMENT DATE BEFORE March 1, 2015)
Pelican Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	PELICAN HRA1000	
	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
RETIREE ONLY	$2,000	$4,000
FAMILY	$4,000	$8,000
MEDICAL OUT-OF-POCKET MAXIMUM - APPLIES TO EACH COVERED PERSON		
RETIREE ONLY	$3,000	$10,000
FAMILY (Medicare Paying Primary for ONE)	$8,000	$20,000
FAMILY (Medicare Paying Primary for TWO)	$6,000	$20,000
FAMILY (Medicare Paying Primary for THREE)	$4,000	$20,000
PRESCRIPTION OUT-OF-POCKET MAXIMUM - APPLIES TO EACH COVERED PERSON		
EACH COVERED PERSON	$2,000	
STATE FUNDING	**THE PLAN PAYS**	
RETIREE ONLY	**$1,000**	
FAMILY	**$2,000**	
	Funding not applicable to pharmacy expenses.	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICIANS' SERVICES		
Preventative Care **Primary Care Physician or Specialist Office or Clinic**	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
Primary Care Physician or Specialist Office - Treatment of illness or injury	80% coverage; subject to deductible	60% coverage; subject to deductible
Maternity Care (prenatal, delivery and postpartum)	80% coverage; subject to deductible	60% coverage; subject to deductible
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
Physician Services for Emergency Room Care	80% coverage; subject to deductible	80% coverage; subject to deductible
Outpatient Surgery/ Services When billed as office visit	80% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/ Services When billed as outpatient surgery at a facility	80% coverage; subject to deductible	60% coverage; subject to deductible
HOSPITAL SERVICES		
Inpatient Services Inpatient care, delivery and inpatient short-term acute rehabilitation services	80% coverage; subject to deductible	60% coverage; subject to deductible

This comparison chart is a summary of plan features and is presented for general information only. It is not a guarantee of coverage.
NOTE: Prior Authorizations and Visit Limits may apply to some benefits - refer to your Plan Document for details.

Medicare Retirees
(RETIREMENT DATE BEFORE March 1, 2015)
Pelican Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	PELICAN HRA1000	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
HOSPITAL SERVICES		
Outpatient Surgery/Services Hospital / Facility	80% coverage; subject to deductible	60% coverage; subject to deductible
Emergency Room - Hospital (Facility) Treatment of an emergency medical condition or injury	80% coverage; subject to deductible	80% coverage; subject to deductible
BEHAVIORAL HEALTH		
Mental Health and Substance Abuse Inpatient Facility	80% coverage; subject to deductible	60% coverage; subject to deductible
Mental Health and Substance Abuse Outpatient Visits - Professional	80% coverage; subject to deductible	60% coverage; subject to deductible
OTHER COVERAGE		
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
Chiropractic Care	80% coverage; subject to deductible	60% coverage; subject to deductible
Urgent Care Center	80% coverage; subject to deductible	60% coverage; subject to deductible
Home Health Care Services	80% coverage; subject to deductible	60% coverage; subject to deductible
Skilled Nursing Facility Services	80% coverage; subject to deductible	60% coverage; subject to deductible
Hospice Care	80% coverage; subject to deductible	60% coverage; subject to deductible
Durable Medical Equipment (DME) Rental or Purchase	80% coverage; subject to deductible	60% coverage; subject to deductible
Hearing Aid Not covered for individuals age eighteen (18) and older	80% coverage; subject to deductible	NO COVERAGE
Transplant Services	80% coverage; subject to deductible	NO COVERAGE
PHARMACY		
Tier 1 - Generic	50% up to $30 [1]	
Tier 2 - Preferred	50% up to $55 [1,2]	
Tier 3 - Non-Preferred	65% up to $80 [1,2]	
Tier 4 - Specialty	50% up to $80 [1,2]	
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	
Tier 2 - Preferred	$20 copay	
Tier 3 - Non-Preferred	$40 copay	
Tier 4 - Specialty	$40 copay	

[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).

Medicare Retirees
(RETIREMENT DATE BEFORE March 1, 2015)
Magnolia Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	MAGNOLIA LOCAL		MAGNOLIA LOCAL PLUS		MAGNOLIA OPEN ACCESS	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE						
RETIREE ONLY	$0	NO COVERAGE	$0	NO COVERAGE	$300	
RETIREE + 1	$0	NO COVERAGE	$0	NO COVERAGE	$600	
RETIREE + 2 OR MORE	$0	NO COVERAGE	$0	NO COVERAGE	$900	
MEDICAL OUT-OF-POCKET MAXIMUM - MEDICARE PRIMARY PAYER FOR AT LEAST ONE PARTICIPANT						
RETIREE ONLY	$0	NO COVERAGE	$500	NO COVERAGE	$1,300	
RETIREE + 1	$1,000	NO COVERAGE	$1,500	NO COVERAGE	$3,600	
RETIREE + 2 OR MORE	$2,000	NO COVERAGE	$2,500	NO COVERAGE	$5,900	
MEDICAL OUT-OF-POCKET MAXIMUM - MEDICARE PRIMARY PAYER FOR AT LEAST TWO PARTICIPANTS						
RETIREE + 1	$0	NO COVERAGE	$0	NO COVERAGE	$1,600	
RETIREE + 2 OR MORE	$1,000	NO COVERAGE	$1,500	NO COVERAGE	$3,900	
MEDICAL OUT-OF-POCKET MAXIMUM - MEDICARE PRIMARY PAYER FOR AT LEAST THREE PARTICIPANTS						
RETIREE + 2 OR MORE	$0	NO COVERAGE	$0	NO COVERAGE	$1,900	
PRESCRIPTION OUT-OF-POCKET MAXIMUM - APPLIES TO EACH COVERED PERSON						
EACH COVERED PERSON	$1,000		$1,500		$2,000	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICIANS' SERVICES						
Preventative Care Primary Care Physician or Specialist Office or Clinic For a complete list of benefits, refer to the Preventive and Wellness/ Routine	100% coverage; not subject to deductible	NO COVERAGE	100% coverage; not subject to deductible	NO COVERAGE	100% coverage; not subject to deductible	80% coverage; subject to deductible
Primary Care Physician or Specialist Office - Treatment of illness or injury	100% coverage after a $25 PCP or $50 SPC copay per visit	NO COVERAGE	100% coverage after a $25 PCP or $50 SPC copay per visit	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
Maternity Care (prenatal, delivery and postpartum)	100% coverage; after a $90 copay per pregnancy	NO COVERAGE	100% coverage; after a $90 copay per pregnancy	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
Physician Services Furnished in a Hospital Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist.	100% coverage; subject to deductible	NO COVERAGE	100% coverage; subject to deductible	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible

PCP = Primary Care Provider; SPC = Specialist

Medicare Retirees
(RETIREMENT DATE BEFORE March 1, 2015)
Magnolia Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	MAGNOLIA LOCAL		MAGNOLIA LOCAL PLUS		MAGNOLIA OPEN ACCESS	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICIANS' SERVICES						
Physician Services for Emergency Room Care	100% coverage; subject to deductible	100% coverage; subject to deductible	100% coverage; subject to deductible	100% coverage; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible
Outpatient Surgery/ Services When billed as office visits	100% coverage; after a $25 PCP or $50 SPC copay per visit	NO COVERAGE	100% coverage; after a $25 PCP or $50 SPC copay per visit	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
HOSPITAL SERVICES						
Inpatient Services Inpatient care, delivery and inpatient short-term acute rehabilitation services	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	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
Outpatient Surgery/ Services Hospital / Facility	100% coverage; after a $100 facility copay per visit	NO COVERAGE	100% coverage; after a $100 facility copay per visit	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
Emergency Room - Hospital (Facility) Treatment of an emergency medical condition or injury	100% coverage after $200 copay per visit; waived if admitted	100% coverage after $200 copay per visit; waived if admitted	100% coverage after $200 copay per visit; waived if admitted	100% coverage after $200 copay per visit; waived if admitted	80% coverage; subject to deductible; $200 copay per visit; waived if admitted	80% coverage; subject to deductible; $200 copay per visit; waived if admitted
BEHAVIORAL HEALTH						
Mental Health and Substance Abuse Inpatient Facility	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	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
Mental Health and Substance Abuse Outpatient Visits - Professional	100% coverage; after a $25 copay per visit	NO COVERAGE	100% coverage; after a $25 copay per visit	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
OTHER COVERAGE						
Outpatient Acute Short-Term Rehabilitation Services Physical Therapy, Speech Therapy, Occupational Therapy, Other short term rehabilitative services	100% coverage; after a $25 copay per visit	NO COVERAGE	100% coverage; after a $25 copay per visit	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
Chiropractic Care	100% coverage; after a $25 copay per visit	NO COVERAGE	100% coverage; after a $25 copay per visit	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible

PCP = Primary Care Provider; SPC = Specialist

Medicare Retirees
(RETIREMENT DATE BEFORE March 1, 2015)
Magnolia Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	MAGNOLIA LOCAL		MAGNOLIA LOCAL PLUS		MAGNOLIA OPEN ACCESS	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
OTHER COVERAGE						
Urgent Care Center	100% coverage after a $50 copay per visit	NO COVERAGE	100% coverage after a $50 copay per visit	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
Home Health Care Services	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE
Skilled Nursing Facility Services	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	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
Hospice Care	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE
Durable Medical Equipment (DME) - Rental or Purchase	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; subject to deductible; 100% in excess of $5,000 per plan year	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
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	80% coverage; subject to deductible
Transplant Services	100% coverage; subject to deductible	NO COVERAGE	100% coverage; subject to deductible	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
PHARMACY						
Tier 1 - Generic	50% up to $30 [1]					
Tier 2 - Preferred	50% up to $55 [1,2]					
Tier 3 - Non-Preferred	65% up to $80 [1,2]					
Tier 4 - Specialty	50% up to $80 [1,2]					
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					
Tier 2 - Preferred	$20 copay					
Tier 3 - Non-Preferred	$40 copay					
Tier 4 - Specialty	$40 copay					

[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).

This comparison chart is a summary of plan features and is presented for general information only. It is not a guarantee of coverage.
NOTE: Prior Authorizations and Visit Limits may apply to some benefits - refer to your Plan Document for details.

Medicare Retirees
(RETIREMENT DATE ON or AFTER March 1, 2015)
Pelican Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	PELICAN HRA1000 HIGH DEDUCTIBLE HEALTH PLAN	
	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
RETIREE ONLY	$2,000	$4,000
FAMILY	$4,000	$8,000
MEDICAL OUT-OF-POCKET MAXIMUM - APPLIES TO EACH COVERED PERSON		
RETIREE ONLY	$3,000	$10,000
FAMILY (MEDICARE PRIMARY PAYER ON AT LEAST ONE)	$8,000	$20,000
FAMILY (MEDICARE PRIMARY PAYER ON AT LEAST TWO)	$6,000	$20,000
FAMILY (MEDICARE PRIMARY PAYER ON AT LEAST THREE)	$4,000	$20,000
PRESCRIPTION OUT-OF-POCKET MAXIMUM - APPLIES TO EACH COVERED PERSON		
EACH COVERED PERSON	$2,000	
STATE FUNDING	**THE PLAN PAYS**	
RETIREE ONLY	**$1,000**	
FAMILY	**$2,000**	
	Funding not applicable to pharmacy Expenses.	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICIANS' SERVICES		
Preventative Care **Primary Care Physician or Specialist Office or Clinic** For a complete list of benefits, refer to the Preventive and Wellness/Routine	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
Primary Care Physician or Specialist Office - Treatment of illness or injury	80% coverage; subject to deductible	60% coverage; subject to deductible
Maternity Care (prenatal, delivery and postpartum)	80% coverage; subject to deductible	60% coverage; subject to deductible
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
Physician Services for Emergency Room Care	80% coverage; subject to deductible	80% coverage; subject to deductible
Outpatient Surgery/ Services When billed as office visits	80% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/ Services When billed as outpatient surgery at a facility	80% coverage; subject to deductible	60% coverage; subject to deductible
HOSPITAL SERVICES		
Inpatient Services Inpatient care, delivery and inpatient short-term acute rehabilitation services	80% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/Services Hospital / Facility	80% coverage; subject to deductible	60% coverage; subject to deductible
Emergency Room - Hospital (Facility) Treatment of an emergency medical condition or injury	80% coverage; subject to deductible	80% coverage; subject to deductible

Medicare Retirees
(RETIREMENT DATE ON or AFTER March 1, 2015)
Pelican Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	PELICAN HRA1000 High Deductible Plan	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
BEHAVIORAL HEALTH		
Mental Health and Substance Abuse Inpatient Facility	80% coverage; subject to deductible	60% coverage; subject to deductible
Mental Health and Substance Abuse Outpatient Visits - Professional	80% coverage; subject to deductible	60% coverage; subject to deductible
OTHER COVERAGE		
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
Chiropractic Care	80% coverage; subject to deductible	60% coverage; subject to deductible
Urgent Care Center	80% coverage; subject to deductible	60% coverage; subject to deductible
Home Health Care Services	80% coverage; subject to deductible	60% coverage; subject to deductible
Skilled Nursing Facility Services	80% coverage; subject to deductible	60% coverage; subject to deductible
Hospice Care	80% coverage; subject to deductible	60% coverage; subject to deductible
Durable Medical Equipment (DME) - Rental or Purchase	80% coverage; subject to deductible	60% coverage; subject to deductible
Hearing Aid Not covered for individuals age eighteen (18) and older	80% coverage; subject to deductible	NO COVERAGE
Transplant Services	80% coverage; subject to deductible	NO COVERAGE
PHARMACY		
Tier 1 - Generic	50% up to $30 [1]	
Tier 2 - Preferred	50% up to $55 [1,2]	
Tier 3 - Non-Preferred	65% up to $80 [1,2]	
Tier 4 - Specialty	50% up to $80 [1,2]	
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	
Tier 2 - Preferred	$20 copay	
Tier 3 - Non-Preferred	$40 copay	
Tier 4 - Specialty	$40 copay	

[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).

This comparison chart is a summary of plan features and is presented for general information only. It is not a guarantee of coverage.
NOTE: Prior Authorizations and Visit Limits may apply to some benefits - refer to your Plan Document for details.

Medicare Retirees
(RETIREMENT DATE ON or AFTER March 1, 2015)
Magnolia Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	MAGNOLIA LOCAL		MAGNOLIA LOCAL PLUS		MAGNOLIA OPEN ACCESS	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE						
RETIREE ONLY	$400	NO COVERAGE	$400	NO COVERAGE	$900	$900
RETIREE + 1	$800	NO COVERAGE	$800	NO COVERAGE	$1,800	$1,800
RETIREE + 2 OR MORE	$1,200	NO COVERAGE	$1,200	NO COVERAGE	$2,700	$2,700
MEDICAL OUT-OF-POCKET MAXIMUM -MEDICARE PRIMARY PAYER FOR AT LEAST ONE PARTICIPANT						
RETIREE	$500	NO COVERAGE	$1,500	NO COVERAGE	$1,500	$4,700
RETIREE + 1	$3,000	NO COVERAGE	$4,000	NO COVERAGE	$4,000	$8,500
RETIREE + 2 OR MORE	$5,500	NO COVERAGE	$6,500	NO COVERAGE	$6,500	$12,250
MEDICAL OUT-OF-POCKET MAXIMUM -MEDICARE PRIMARY PAYER FOR AT LEAST TWO PARTICIPANTS						
RETIREE + 1	$1,000	NO COVERAGE	$2,000	NO COVERAGE	$2,000	$8,500
RETIREE + 2 OR MORE	$3,5000	NO COVERAGE	$4,000	NO COVERAGE	$4,500	$12,250
MEDICAL OUT-OF-POCKET MAXIMUM -MEDICARE PRIMARY PAYER FOR AT LEAST THREE PARTICIPANTS						
RETIREE + 2 OR MORE	$1,500	NO COVERAGE	$2,500	NO COVERAGE	$2,500	$12,250
PRESCRIPTION OUT-OF-POCKET MAXIMUM -APPLIES TO EACH COVERED PERSON						
EACH COVERED PERSON	$2,000		$2,000		$2,000	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICIANS' SERVICES						
Preventative Care Primary Care Physician or Specialist Office or Clinic For a complete list of benefits, refer to the Preventive and Wellness/ Routine	100% coverage	NO COVERAGE	100% coverage	NO COVERAGE	100% coverage; not subject to deductible	80% coverage; subject to deductible
Primary Care Physician or Specialist Office - Treatment of illness or injury	100% coverage after a $25 PCP or $50 SPC copay per visit	NO COVERAGE	100% coverage after a $25 PCP or $50 SPC copay per visit	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
Maternity Care (prenatal, delivery and postpartum)	100% coverage; after a $90 copay per pregnancy	NO COVERAGE	100% coverage; after a $90 copay per pregnancy	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
Physician Services Furnished in a Hospital Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist.	100% coverage	NO COVERAGE	100% coverage	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
Physician Services for Emergency Room Care	100% coverage; subject to deductible	100% coverage; subject to deductible	100% coverage; subject to deductible	100% coverage; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible

Medicare Retirees
(RETIREMENT DATE ON or AFTER March 1, 2015)
Magnolia Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	MAGNOLIA LOCAL		MAGNOLIA LOCAL PLUS		MAGNOLIA OPEN ACCESS	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICIANS' SERVICES						
Outpatient Surgery/ Services When billed as office visits	100% coverage; after a $25 PCP or $50 SPC copay per visit	NO COVERAGE	100% coverage; after a $25 PCP or $50 SPC copay per visit	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
Outpatient Surgery/ Services When billed as outpatient surgery at a facility	100% coverage	NO COVERAGE	100% coverage	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
HOSPITAL SERVICES						
Inpatient Services Inpatient care, delivery and inpatient short-term acute rehabilitation services	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	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible + $50 copay per day (days 1 - 50)
Outpatient Surgery/ Services Hospital / Facility	100% coverage; after a $100 facility copay per visit	NO COVERAGE	100% coverage; after a $100 facility copay per visit	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
Emergency Room - Hospital (Facility) Treatment of an emergency medical condition or injury	100% coverage after $200 copay per visit; waived if admitted	100% coverage after $200 copay per visit; waived if admitted	100% coverage after $200 copay per visit; waived if admitted	100% coverage after $200 copay per visit; waived if admitted	80% coverage; subject to deductible; $200 copay per visit; waived if admitted	80% coverage; subject to deductible; $200 copay per visit; waived if admitted
BEHAVIORAL HEALTH						
Mental Health and Substance Abuse Inpatient Facility	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	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible + $50 copay per day (days -5)
Mental Health and Substance Abuse Outpatient Visits - Professional	100% coverage; after a $25 copay per visit	NO COVERAGE	100% coverage; after a $25 copay per visit	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
OTHER COVERAGE						
Outpatient Acute Short-Term Rehabilitation Services Physical Therapy, Speech Therapy, Occupational Therapy, Other short term rehabilitative services	100% coverage; after a $25 copay per visit	NO COVERAGE	100% coverage; after a $25 copay per visit	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
Chiropractic Care	100% coverage; after a $25 copay per visit	NO COVERAGE	100% coverage; after a $25 copay per visit	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible

PCP = Primary Care Provider; SPC = Specialist

Medicare Retirees
(RETIREMENT DATE ON or AFTER March 1, 2015)
Magnolia Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	MAGNOLIA LOCAL		MAGNOLIA LOCAL PLUS		MAGNOLIA OPEN ACCESS	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
OTHER COVERAGE						
Urgent Care Center	100% coverage after a $50 copay per visit	NO COVERAGE	100% coverage after a $50 copay per visit	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
Home Health Care Services	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE
Skilled Nursing Facility Services	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	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible + $50 copay per day (days 1 - 50)
Hospice Care	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE
Durable Medical Equipment (DME) - Rental or Purchase	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; subject to deductible; 100% in excess of $5,000 per plan year	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
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	80% coverage; subject to deductible
Transplant Services	100% coverage	NO COVERAGE	100% coverage	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
PHARMACY						
Tier 1 - Generic	50% up to $30 [1]					
Tier 2 - Preferred	50% up to $55 [1,2]					
Tier 3 - Non-Preferred	65% up to $80 [1,2]					
Tier 4 - Specialty	50% up to $80 [1,2]					
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					
Tier 2 - Preferred	$20 copay					
Tier 3 - Non-Preferred	$40 copay					
Tier 4 - Specialty	$40 copay					

[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).

This comparison chart is a summary of plan features and is presented for general information only. It is not a guarantee of coverage.
NOTE: Prior Authorizations and Visit Limits may apply to some benefits - refer to your Plan Document for details.

NOTES

OFFICE OF GROUP BENEFITS

ogb

LOUISIANA







ACCESS2DAY HEALTH

PELICAN HRA1000, MAGNOLIA LOCAL, MAGNOLIA LOCAL PLUS AND MAGNOLIA OPEN ACCESS PLAN MEMBERS

ACCESS 2day HEALTH

OFFICE OF GROUP BENEFITS ogb LOUISIANA

The Office of Group Benefits has partnered with Access2day Health clinics to deliver primary and urgent care at no additional cost for members enrolled in the following plans*:

Pelican HRA1000 | Magnolia Local | Magnolia Local Plus | Magnolia Open Access

**Benefit not available to those on HSA plans due to federal regulations.*

Members and their qualified dependents on these 4 health plans receive urgent care and primary care services with:

NO Copay

NO Out-of-Pocket Expenses

NO Appointment Necessary

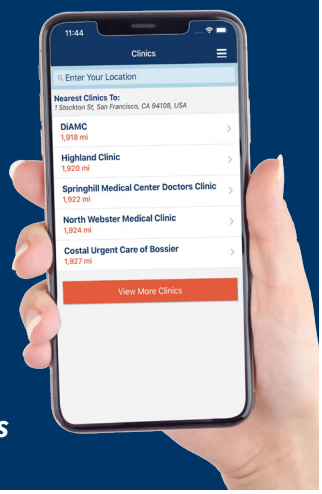
NO Extended Wait Times

Treatments available at Access Health clinics include, but are not limited to:

- Respiratory Conditions
- Fractures
- Head, Eye & Ear Conditions
- Lacerations & Cuts
- Digestive & Urinary Conditions
- Skin, Hair & Nail Conditions
- Preventative Health Care
- Basic Lab Work
- Vaccinations & Shots
- Routine Physicals
- Screening Panels
- Specialty Referrals

Find the clinic nearest you!

Access2day has more than 90 clinic locations across Louisiana!



ANDROID APP ON Google Play

Available on the App Store

*Download the Clinic Finder App or visit **access2dayhealth.com/locations***







OTHER BENEFIT OFFERINGS

Term life insurance

Term life insurance

Life insurance through OGB is a term life policy not an individual policy; therefore, there is no cash value. OGB offers three term life insurance plans through Prudential. Details about the Basic Life, Enhanced Life and the Basic Plus Supplemental plans and the corresponding amounts of dependent insurance offered are noted below:

Basic Life			
Option 1		**Option 2**	
Employee	$5,000	Employee	$5,000
Spouse	$1,000	Spouse	$2,000
Each Dependent	$500	Each Dependent	$1,000
Enhanced Basic			
Option 1		**Option 2**	
Employee	$15,000	Employee	$15,000
Spouse	$1,000	Spouse	$2,000
Each Dependent	$500	Each Dependent	$1,000
Basic Plus Supplemental			
Option 1		**Option 2**	
Employee	Schedule to max of $50,000*	Employee	Schedule to max of $50,000*
Spouse	$2,000	Spouse	$4,000
Each Dependent	$1,000	Each Dependent	$2,000
**** Amount based on employee's annual salary***			

Important Notes

- During Annual Enrollment, Plan members and dependents can enroll in Basic, Enhanced Basic, and Basic Supplemental Coverages.
- Once enrolled in term life insurance, you do not have to re-enroll every year. Your coverage elections will be continued each year until you make a change, turn 65 or your salary changes.
    - Members enrolled in term life insurance coverage will automatically have 25 percent reduced coverage on January 1 following their 65th birthday. Another automatic 25 percent reduction in coverage will take effect on January 1 following their 70th birthday. Premium rates will be reduced accordingly.
- Newly hired employees who apply for term life insurance within 30 days of employment are eligible for term life insurance without providing evidence of insurability (EOI).
- Existing Active Employees may only apply for term life insurance during OGB annual enrollment. These employees may be required to provide evidence of insurability to the insurer.
    - Plan members should contact their HR departments to assist them with completing and submitting the Evidence of Insurability Form to Prudential for approval.
- Members currently enrolled who wish to add dependent life coverage for a spouse can do so within 30 days of marriage or by providing evidence of insurability during annual enrollment. Eligible dependent children can be added without providing evidence of insurability to the insurer.
- Member pays 50 percent of their term life insurance premium and 100 percent of dependent term life insurance premium
- If the request for life coverage is approved, Prudential will provide the plan member and dependent spouse an EOI approval letter to give to their HR representative to submit to OGB. Coverage will begin either on 1/1/2027 or the 1st of the month after OGB receives the approval letter and GB01.
- Plan members can remove dependent Ex-spouses and step-children outside of the 30 days the qualified life event took place. Please submit a GB01 to your HR department along with a copy of the Final judgment of Divorce. The effective date of coverage will be 1/1/2027.

Who is Eligible?

Basic, Enhanced Basic and Basic Plus Supplemental Plans

- Full-Time Employees
- Retirees who took coverage into retirement

Dependent Life

- Covered employee's legal Spouse
- Your Other Eligible Dependents up to applicable attainment age

Please Note: Ex-Spouse(s) and step-children are no longer eligible for dependent life coverage. Plan member must drop dependent life coverages within 30 days. Submit a GB-01 and a copy of the final Judgment of Divorce Decree to OGB within 30 days of signed Judgment. **No life claim(s) will be paid on Ex-Spouse or step-children by Life Insurance company.**

Please visit the link below or Scan the QR code to complete the EOI.
https://gi.prudential.com/POGH/Controller/standalone?VR=WmR5RWxtZEZ3OTFHMWZlejl0ZmU3dz09

Portability of Term life insurance

Members can take advantage of the portability provision and continue coverage at group rates. This coverage is for terminated employees and employees whose face amount is reduced. Such coverage will be at a higher rate, and the state will not contribute any portion of the premium. The insurer will determine premium rates. You do not need to submit an evidence of insurability form to continue coverage. The insurer must receive the application no later than 31-days from the date their Employee Term Life Coverage ends.

Conversion of Term life insurance

Employees may convert life coverage when employment or eligibility ends, subject to the "Conversion" section of your Contract/Booklet Certificate. No Evidence of Insurability is needed. Accidental Death & Dismemberment coverage cannot be converted. In most cases, the insurer must receive the signed Notice of Group Life Conversion Privilege form within 31-days from the date their Optional Employee Term Life Coverage ends.

Accidental Death and Dismemberment Benefits

Accidental Death & Dismemberment (AD&D) benefits are included for all active and retired employees through age sixty-nine (69). For those members who are actively employed at the age of 70 and older, the AD&D coverage will continue until the member retires. Upon retirement, the AD&D coverage will terminate at midnight on the last day of the month in which the member retired.

Death Notification

Please notify the human resources office at the member's agency (or former agency, if retired) when a member or covered dependent dies. A certified copy of the death certificate must be provided to the member's agency.

For a complete Basic, Enhanced Basic and Basic Plus Supplemental Term life insurance schedule visit ogb.la.gov.

NOTES

Prudential

IMPORTANT INFORMATION ABOUT BENEFICIARY DESIGNATIONS

Use this form to designate or make changes to the beneficiary(ies) of your Group Insurance death proceeds. The information on this form will replace any prior beneficiary designation. You may name anyone or any entity as your beneficiary and you may change your beneficiary at any time by completing a new Group Insurance Beneficiary Designation/Change form. Common designations include individuals, estates, corporation/organizations and trusts. **Payment will be made to the named beneficiary. If there is no named beneficiary, or the named beneficiary predeceased the insured, settlement will be made in accordance with the terms of your Group Contract.**

DEFINITIONS

You may find the following definitions helpful in completing this form:

Primary Beneficiary(ies) – the person(s) or entity you choose to receive your life insurance proceeds. Payment will be made in equal shares unless otherwise specified. In the event that a designated primary beneficiary predeceases the insured, the proceeds will be paid to the remaining primary beneficiaries in equal shares or all to the sole remaining primary beneficiary.

Contingent Beneficiary(ies) – the person(s) or entity you choose to receive your life insurance proceeds if the primary beneficiary(ies) die (or the entity dissolves) before you die. Payment will be made in equal shares unless otherwise specified. In the event that a designated contingent beneficiary predeceases the insured, the proceeds will be paid to the remaining contingent beneficiaries in equal shares or all to the sole remaining contingent beneficiary.

INSTRUCTIONS FOR DESIGNATING A PRIMARY OR CONTINGENT BENEFICIARY

1. EMPLOYEE INFORMATION

- All information in this section is required.
- Unless otherwise indicated in Section 1, the information supplied on the form will apply to ALL coverages offered under the employer's group plan.
- Unless otherwise indicated in Section 2, the information supplied on the form will apply to all the Group Life coverage(s) issued by The Prudential Insurance Company of America to the group contract holder.

2. BENEFICIARY DESIGNATION

- You may name more than one primary and more than one contingent beneficiary. This form allows you to name up to four primary and four contingent beneficiaries. If you need additional space, please attach a separate sheet of paper.
- Please indicate the percentage share designated to each primary beneficiary. **The total for all primary beneficiaries must equal 100%.** If no percentages are specified, the proceeds will be split evenly among those named. Payment will be made to the named beneficiary. If there is no named beneficiary, or the named beneficiary predeceased the insured, settlement will be made in accordance with the terms of your Group Contract. **If designating percentages for contingent beneficiaries, the percentage for all contingent beneficiaries must also equal 100%.**
- You can name an individual, corporation/organization, trust, or an estate as a beneficiary. The following examples may be helpful in designating beneficiaries:

Individual: "Mary A. Doe"
- Each name should be listed as first name, middle initial, last name ("Mary A. Doe," not "Mrs. M. Doe")
- Include the address, telephone number, social security number, relationship and Date of Birth for each individual listed.
- Indicate the percentage to be assigned to each individual.

Estate: "Estate of the Insured"
- Select "Other" as the Beneficiary Description and write "Estate" in the blank space provided.
- Indicate the percentage to be assigned to the Estate of the Insured.

Corporation/Organization: "ABC Charitable Organization"
- Select "Corporation/Organization" as the Beneficiary Description.
- Write the legal name of the corporation or organization in the space for the Beneficiary's First Name.
- Include the address, city and state, telephone number and tax ID number of operation for each organization or corporation listed.
- Indicate the percentage to be assigned to the corporation or organization.

Trust: "The John Doe Trust. A Trust with a trust agreement dated 1/1/99 whose Trustee is Jane Smith."
- Select "Trust" as the Beneficiary Description.
- Indicate the percentage to be assigned to the trust.
- Complete Section 3, Trust Designation.

3. TRUST DESIGNATION

- Complete this section if you have named a trust as a primary or contingent beneficiary in Section 2. Fill in the name and address for each trustee.
- Fill in the title and date of the Trust Agreement in the space provided.

4. AUTHORIZATION/SIGNATURE

- The employee must read, sign and date the authorization.
- Submit the completed form to your Benefits Administrator or Human Resources (as directed by your employer) and keep a copy for your records.

Prudential

Group Insurance Beneficiary Designation/Change

DATE: ____/____/____

1. EMPLOYEE INFORMATION (please print)

Last Name	First Name	MI	Employee ID# (if applicable)	Marital Status (check one) ☐ Married ☐ Widowed ☐ Single ☐ Divorced	Gender (check one) ☐ Male ☐ Female	Has this insurance been assigned? ☐ Yes ☐ No

Address	City	State	ZIP Code	Daytime Phone	Home Phone	Date of Birth	Date of Hire	Date of Retirement (if applicable)

Name of Employer/Group Policyholder	Group Policy No.	Unless otherwise indicated below, this Beneficiary Designation/Change form applies to ALL coverages offered under my employer's group plan. This form applies only to ☐ Basic Life ☐ Basic AD&D ☐ Optional Term Life ☐ Optional AD&D ☐ GUL ☐ GVUL coverage(s).

2. BENEFICIARY DESIGNATION: I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies), if any, and in the event of my death, designate the following:

A. Primary Beneficiaries

Beneficiary Description (check one)	First Name	MI	Last Name	Address (include city, state, ZIP)	Relationship	Date of Birth	SSN/Tax ID Number	Phone	% Share
☐ Individual ☐ Other _____ ☐ Trust ☐ Corporation/Organization									
☐ Individual ☐ Other _____ ☐ Trust ☐ Corporation/Organization									
☐ Individual ☐ Other _____ ☐ Trust ☐ Corporation/Organization									
☐ Individual ☐ Other _____ ☐ Trust ☐ Corporation/Organization									
							TOTAL: (Must equal 100%)		

B. Contingent Beneficiaries

Beneficiary Description (check one)	First Name	MI	Last Name	Address (include city, state, ZIP)	Relationship	Date of Birth	SSN/Tax ID Number	Phone	% Share
☐ Individual ☐ Other_____ ☐ Trust ☐ Corporation/Organization									
☐ Individual ☐ Other _____ ☐ Trust ☐ Corporation/Organization									
☐ Individual ☐ Other_____ ☐ Trust ☐ Corporation/Organization									
☐ Individual ☐ Other _____ ☐ Trust ☐ Corporation/Organization									
							TOTAL: (Must equal 100%)		

3. TRUST DESIGNATION - COMPLETE IF A TRUST HAS BEEN NAMED AS A BENEFICIARY IN SECTION 2

Trustee's Name (First, MI, Last)	Address (include city, state, ZIP)

And successor(s) in trust, as Trustee(s) under _____ **dated** _____ **as amended and executed by me and said Trustee.**

Title of Agreement — Date of Agreement

Prudential

Group Insurance Beneficiary Designation/Change

4. **AUTHORIZATION/SIGNATURE** I authorize my plan administrator to record and consider the individuals/institutions that I have named on this form as beneficiaries for benefits under the applicable employee benefit plans. If designating a trust as a beneficiary, I understand Prudential assumes no obligation as to the validity or sufficiency of any executed Trust Agreement and does not pass on its legality. In making payment to any Trustee(s), Prudential has the right to assume that the Trustee(s) is acting in a fiduciary capacity until notice to the contrary is received by Prudential at its Group Life Claim office. I agree that if Prudential makes any payment(s) to the Trustee(s) before notice is received, Prudential will not make payment(s) again.

Employee's Signature X_____ Date Signed _____

The employee must sign and date this form. The signature date must be the date the employee actually signed the form.

Group Life coverage(s) are issued by The Prudential Insurance Company of America, a New Jersey company, 751 Broad Street, Newark, NJ 07102. Group Variable Universal Life Insurance is distributed by Prudential Investment Management Services LLC, 655 Broad Street, 19TH Floor, Newark, NJ 07102, a registered broker/dealer and a Prudential Financial company. Please refer to the Booklet-Certificate, which is made a part of the Group Contract, for all plan details, including any exclusions, limitations and restrictions which may apply. Contract provisions may vary by state. Contract series: 83500 (Term Life), 89579 (Group Variable Universal Life), 96945 (Group Universal Life).

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OTHER BENEFIT OFFERINGS

Flexible Spending Arrangement

Flexible Benefits Program *(Active Employees and Rehired Retirees)*

You could save money and reduce your taxes by enrolling in one or more of these benefits.

Option	Description	Consider if:	Do you have to re-enroll each year?
Premium Conversion*	Your eligible premiums are paid with pre-tax dollars through payroll deductions.	You want to increase your take-home pay	**No**
General-Purpose Health Care Flexible Spending Arrangement (GPFSA)	Allows you to pay with pre-tax dollars certain qualifying medical care expenses for you, your spouse, and your eligible tax dependents.	You pay out-of-pocket medical expenses, such as health plan copayments, health plan deductibles, vision expenses, dental expenses, etc.	**Yes**
Limited-Purpose Dental/Vision Flexible Spending Arrangement (LPFSA)	Allows you to pay with pre-tax dollars dental and vision expenses for you, your spouse, and your eligible tax dependents, while you maintain your eligibility to contribute to your HSA.	You are enrolled in the Pelican HSA775	**Yes**
Dependent Care Flexible Spending Arrangement (DCFSA)	Allows you to pay with pre-tax dollars eligible dependent care expenses for your eligible dependents under age 13 or for a spouse, parent, or other dependent who is incapable of self-care.	You pay for the care of your eligible dependent(s) while you are at work.	**Yes**

*All employees of agencies that participate in the OGB administered Flexible Benefits Plan will automatically be enrolled in the Premium Conversion option. See the Flex Plan document for additional information.

Who is eligible?

In general, active, full-time employees (as defined by employer) are eligible.

Rehired retirees who are employed as active, benefit-eligible employees are eligible to participate in the FSA if their annual elected amount is deducted from their active payroll check and as long as they are not enrolled in Medicare.

Employees can participate in the General-Purpose Health Care FSA, the Limited-Purpose Dental/Vision FSA or the Dependent Care FSA benefit even if they are not enrolled in an OGB health plan or the Premium Conversion benefit!

Annual FSA Enrollment Process:

1. Employees selecting an FSA for the first time must enroll through their Human Resources department by completing a Flexible Spending Arrangement Enrollment\Stop Form (GB-02).can enroll in FSAs on-line at the same time they enroll in their OGB health plan through the annual enrollment portal, or
2. Employees re-enrolling can use the appropriate annual enrollment portal (LEO for LaGov employees, OGB Portal for Non-LaGov employees) or submit a GB-02 to their Human Resources
3. Employees MUST re-enroll in their chosen FSA option EVERY YEAR.

NOTE: Total Administration Services Corporation (TASC) is the FSA Administrator for OGB. More Information about TASC can be found on the next two pages.

NOTES

TASC®

Save money with FSA pretax benefit accounts.



A Flexible Spending Account (FSA) puts more money in your pocket by reducing your taxable income when you contribute pretax dollars to pay for common expenses like these:

HEALTHCARE

- Medical/dental office visit co-pays
- Dental/orthodontic care services
- Prescriptions, vaccinations, and OTC
- Eye exams; prescription glasses/lenses

DEPENDENT CARE

- Daycare expenses
- Before & after school care
- Nanny/nursery school
- Elder care

TIPS

- Determine your elections based on your estimated out-of-pocket expenses for the year
- Your employer may offer other types of Benefit Accounts too; ask for details
- For a complete list of eligible expenses, see IRS Publications 502 & 503 at **irs.gov**

Increase your take-home pay by reducing your taxable income.

Each $1 you contribute to your FSA reduces your taxable income by $1.

With less tax taken, your take-home pay increases!

Consider this example: *(for illustration only)*



Richard has:

- Gross monthly pay of $3,500
- $600 per month in eligible expenses

Here is his net monthly take-home pay:	
Without FSA ($600 spent using post-tax dollars)	**With FSA** ($600 spent using pretax dollars)
$1,932	**$2,098**

That's a net increase in take-home pay of **$166 every month!**

To estimate potential savings based on your income and expenses, use the Tax Savings Calculator at **www.tasconline.com/tasc-calculators**.

See how easy it is to start saving with a TASC Benefit Account. See details on reverse.

How to participate.

It's easy to start saving with an FSA. Just follow 3 simple steps:



1. DECIDE how much you want to contribute.

Check with your employer for plan specifics and review at the IRS limits at **www.tasconline.com/benefits-limits**.

The more you contribute, the lower your taxable income will be.

However, it's important to be conservative when choosing your annual contribution based on your anticipated qualified expenses since:

- The money you contribute to your benefit account can only be used for eligible FSA expenses.
- Any unused FSA funds at the close of the plan year are not refundable to you. *(A grace period or carryover option may be in place for your plan. Check with your employer for plan guidelines and allowances.)*

PLANNING TIPS

START by making a conservative estimate of how much you expect to spend on eligible out-of-pocket expenses for the year.

COMPARE your estimate to the IRS limits. If your estimate is higher than these annual contribution limits, consider making the maximum contribution allowed.

2. ENROLL by completing the enrollment process.

Your contribution will be deducted in equal amounts from each paycheck, pretax, throughout the plan year.

Your total annual contribution to a **Healthcare FSA** will be available to you immediately at the start of the plan year. Alternatively, your **Dependent Care FSA** funds are only available as payroll contributions are made.

SPECIAL FEATURES

MyCash Account: Included on your TASC Card for faster reimbursement deposits and non-benefit purchases.

TASC Mobile App: Track and manage all benefits and access numerous helpful tools, anywhere and anytime! *Search for "TASC" (green icon).*

3. ACCESS your funds easily using the TASC Card.

This convenient card automatically approves and deducts most eligible purchases from your benefit account with no paperwork required. Plus, for purchases made without the card, you can request reimbursement online, by mobile app, or using a paper form.

Reimbursements happen fast—within 12 hours—when you request to have them added to the MyCash balance on your TASC Card. You can use the MyCash balance on your card to get cash at ATMs or to buy anything you want anywhere Mastercard is accepted!



This Mastercard is administered by TASC, a registered agent of Pathward. Use of this card is authorized as set forth in your Cardholder Agreement. The card is issued by Pathward, N.A., Member FDIC, pursuant to license by Mastercard International Incorporated. Mastercard and the circles design are registered trademarks of Mastercard International Incorporated.
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GET IT ON Google Play

Questions? Ask your employer or contact your Plan Administrator:
Total Administration Services Corporation • www.tasconline.com • 1-800-422-4661

FX-4245-082922

TASC®

NOTES







OTHER BENEFIT OFFERINGS

Alternative Coverage, Legal Information, Notice of Creditable Coverage and Terms & Conditions

Alternative Coverage

Louisiana Children's Health Insurance Program (LaCHIP)

LaCHIP is a health insurance program designed to bring quality health care to currently uninsured youth up to the age of 19 in Louisiana. Certain dependents can qualify for coverage under LaCHIP using higher income standards. LaCHIP provides Medicaid coverage for doctor visits for primary care as well as preventive and emergency care, immunizations, prescription medications, hospitalization, home health care and many other health services. LaCHIP provides health care coverage for the dependents of Louisiana's working families with moderate and low incomes. A renewal of coverage is done after each 12-month period.

For complete information about eligibility and benefits, call toll free 1-877-2LaCHIP (1-877-252-2447). Representatives are available Monday - Friday 7:00 a.m. to 5:00 p.m. Central Time. You may also learn more by visiting the Louisiana Department of Health (LDH) website at **ldh.la.gov**.

Health Insurance Marketplace

You may also qualify for a lower cost health insurance plan through the Health Insurance Marketplace under the Affordable Care Act. To find out if you qualify, visit **www.healthcare.gov.**

Legal

Special Enrollment under HIPAA

Under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), if you originally decline enrollment for yourself or your eligible dependents (including your spouse) for certain reasons, or if certain events occur, you may in the future be able to enroll yourself and your dependents in an OGB health plan under HIPAA special enrollment, provided that you request enrollment within 30 days after the qualified life event, or such longer period allowed by federal law. The HIPAA special enrollment events are defined by federal law.

If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, or other events defined by federal HIPAA law, you may be able to enroll yourself and your eligible dependents under special enrollment, provided that you request enrollment within 30 days of acquiring the new dependent. The effective date of coverage for adding a dependent under such special enrollment is the date of the event.

COBRA - Continuation of Coverage

COBRA gives a plan participant and eligible dependents the right to choose to continue OGB health plan coverage for limited periods of time when coverage is lost under circumstances, defined by federal law, such as certain voluntary or involuntary job loss, reduction in hours worked, transition between jobs, death, divorce, and other life events. Individuals who choose COBRA continuation coverage are required to pay 102% of the entire premium for coverage in most situations. Contact your human resources representative of your employing agency.

State of Louisiana
Office of Group Benefits

Heath Williams
Chief Executive Officer



Office of Group Benefits
P.O. Box 44036
Baton Rouge, Louisiana 70804
Phone (800) 272-8451
Fax (225) 342-9919

Important Notice from the Office of Group Benefits (OGB) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with OGB and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a non-OGB sponsored Medicare drug plan. If you are considering joining a non-OGB-sponsored Medicare drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. You should also know that your medical and prescription drug coverage through OGB will terminate if you enroll in a non-OGB sponsored Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. OGB has determined that the prescription drug coverage provided through OGB and administered by **CVS Caremark/SilverScript for Plan Year 2027** is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a non-OGB sponsored Medicare drug plan, your current OGB coverage will be affected. Your current OGB prescription drug coverage is offered in conjunction with your State of Louisiana OGB medical coverage. If you choose another non-OGB sponsored Medicare prescription drug plan, you will lose both your medical and prescription drug coverage from OGB.

If you do decide to join a non-OGB sponsored drug plan, resulting in the cancellation of your current OGB coverage, be aware that you and your dependents, in most cases, will not be able to get OGB coverage back.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with OGB and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage…

Contact OGB Customer Service for further information at 1-800-272-8451. **NOTE:** You will receive this notice each year. You will also receive this notice before the next period you can join a Medicare drug plan, and if this coverage through OGB changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare and You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see inside back cover of your copy of the "Medicare and You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty). If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Date:	September 1, 2026
Name of Entity/Sender:	State of Louisiana Office of Group Benefits
Contact--Position/Office:	OGB Customer Service
Address:	P.O. Box 44036, Baton Rouge, LA 70804
Phone Number:	1-800-272-8451

Terms and Conditions

In this section, "I" refers to the covered employee/retiree.

I understand that it is my responsibility to review the most recent enrollment guide. It is my responsibility to review any applicable Plan communications that are available and applicable to me (including plan documents posted electronically at ogb.la.gov) at the time of my decision, and to determine the OGB option that best meets my or my family's health coverage needs.

I also understand that it is my responsibility to review the following bullets and understand which of the bullets apply to my situation:

- I understand that providers may at any time join or discontinue participation in the network for an OGB health plan, and this is not an OGB Plan-Recognized Qualified Life Event.
- I understand that the costs of prescription drugs may change during a Plan Year and that these changes are not an OGB Plan-Recognized Qualified Life Event.
- I understand that once I have made an election, I will not be able to change that election until the next annual enrollment period, unless I have an OGB Plan-Recognized Qualified Life Event.
- I understand that by electing coverage I am authorizing my employer to deduct from my compensation or monthly check the applicable premium for the plan option I have selected.
- I understand that I will have to pay premiums for the plan option I select, and that coverage for any newly added dependents will start only if I provide the required verification documentation for those dependents by the applicable deadline. Newly-acquired dependent coverage for HIPAA Special Enrollment Events is retroactive to the date of the OGB Plan-Recognized Qualified Life Event if verified by the applicable deadline.
- I understand that I am responsible for the cost of benefits used by me or my covered dependent(s) after the termination date of coverage.
- I understand that it is my responsibility to verify that the correct deduction is taken from my compensation and to immediately notify my employer if it is not correct.
- I understand that if I miss the deadline to add a dependent or submit verification documentation, I will not be able to add the dependent until the next annual enrollment period, or until I experience a subsequent OGB Plan-Recognized Qualified Life Event that would enable me to make such a change.
- I understand that intentional misrepresentation or fraudulent falsification of information (including verification documentation submitted when dependents are added) may subject me to penalties and possible legal action and, in the case of adding dependents, may result in termination of coverage and recovery of payments made by OGB for ineligible dependents.
- I understand that by enrolling in an OGB plan, I am attesting that the information I provide is true and correct to the best of my knowledge, under penalty of law.
- This enrollment guide is presented for general information only. It does not constitute legal advice. It is not a benefit plan, nor is it intended to be construed as a benefit plan document. If there is any inconsistency between this guide and the benefit plan documents and Schedule of Benefits, the FINAL benefit plan documents and Schedule of Benefits will govern the benefits and plan payments.

OFFICE OF GROUP BENEFITS

ogb

LOUISIANA







RATE SHEETS

OFFICE OF GROUP BENEFITS
MEMBER-ONLY SHARE OF MONTHLY PREMIUM RATES
ALL OGB-PARTICIPATING AGENCIES, EXCLUDING PARISH & CITY SCHOOL BOARDS
Rates effective January 1, 2027 (75% employer participation level)

	Magnolia Open Access	Magnolia Local	Magnolia Local Plus	Pelican HSA775	Pelican HRA1000
ACTIVE EMPLOYEE					
ENROLLEE ONLY	$280.46	$228.66	$269.82	$97.48	$168.58
ENROLLEE + 1 (SPOUSE)	$911.20	$742.94	$876.34	$316.78	$547.62
ENROLLEE + 1 (CHILD)	$403.76	$329.12	$388.30	$140.48	$242.78
ENROLLEE + CHILDREN	$403.76	$329.12	$388.30	$140.48	$242.78
FAMILY	$976.28	$796.06	$938.96	$339.34	$586.68
RETIREE WITHOUT MEDICARE & RE-EMPLOYED RETIREE					
ENROLLEE ONLY	$280.46	$228.66	$269.82	N/A	$168.58
ENROLLEE + 1 (SPOUSE)	$911.20	$742.94	$876.34	N/A	$547.62
ENROLLEE + 1 (CHILD)	$403.76	$329.12	$388.30	N/A	$242.78
ENROLLEE + CHILDREN	$403.76	$329.12	$388.30	N/A	$242.78
FAMILY	$917.18	$747.76	$885.06	N/A	$551.18
RETIREE WITH 1 MEDICARE					
ENROLLEE ONLY	$169.70	$138.40	$166.60	N/A	$102.04
ENROLLEE + 1 (SPOUSE)	$627.06	$511.24	$609.00	N/A	$376.86
ENROLLEE + 1 (CHILD)	$293.80	$239.48	$286.66	N/A	$176.56
ENROLLEE + CHILDREN	$293.80	$239.48	$286.66	N/A	$176.56
FAMILY	$835.52	$681.22	$810.54	N/A	$502.14
RETIREE WITH 2 MEDICARE					
ENROLLEE + 1 (SPOUSE)	$305.04	$248.70	$298.66	N/A	$183.32
FAMILY	$377.74	$307.94	$369.78	N/A	$227.02
C.O.B.R.A.					
ENROLLEE ONLY	$1,144.54	$933.14	$1,101.04	$397.88	$687.92
ENROLLEE + 1 (SPOUSE)	$2,431.20	$1,982.16	$2,338.42	$845.24	$1,461.14
ENROLLEE + 1 (CHILD)	$1,395.98	$1,138.06	$1,342.76	$485.54	$839.28
ENROLLEE + CHILDREN	$1,395.98	$1,138.06	$1,342.76	$485.54	$839.28
FAMILY	$2,564.04	$2,090.48	$2,466.14	$891.28	$1,540.86
DISABILITY C.O.B.R.A.					
ENROLLEE ONLY	$1,683.16	$1,372.30	$1,619.12	$585.10	$1,011.66
ENROLLEE + 1 (SPOUSE)	$3,575.34	$2,914.94	$3,438.92	$1,243.06	$2,148.76
ENROLLEE + 1 (CHILD)	$2,052.96	$1,673.64	$1,974.58	$714.02	$1,234.22
ENROLLEE + CHILDREN	$2,052.96	$1,673.64	$1,974.58	$714.02	$1,234.22
FAMILY	$3,770.72	$3,074.28	$3,626.76	$1,310.74	$2,266.00

For a complete list of premium rates for all employer types and at all employer participation levels, please visit info.groupbenefits.org .

NOTES:

1) The breakdown between the State Share and the Employee Share amounts shown may not be accurate for certain school board employees due to local funding that affects agency funding, which affects agency contributions. Total Premium amounts are correct for all non-risk rated agencies.
2) The breakdown between the State Share and Employee Share amounts shown for retirees without Medicare coverage is determined based upon the requirements of LA R.S. 42:851(C)(3), which supersedes the requirements of LA R.S. 42:851(E)(1).
3) All plan members who retired on or after July 1, 1997 must have Medicare Part A and Part B to qualify for reduced premium rates.

OFFICE OF GROUP BENEFITS
MEMBER-ONLY SHARE OF MONTHLY PREMIUM RATES
PARISH & CITY SCHOOL BOARDS ONLY
Rates effective January 1, 2027 (75% employer participation level)

	Magnolia Open Access	Magnolia Local	Magnolia Local Plus	Pelican HSA775	Pelican HRA1000
ACTIVE EMPLOYEE					
ENROLLEE ONLY	$280.46	$228.66	$269.82	$97.48	$199.76
ENROLLEE + 1 (SPOUSE)	$911.20	$742.94	$876.34	$316.78	$648.94
ENROLLEE + 1 (CHILD)	$403.76	$329.12	$388.30	$140.48	$287.70
ENROLLEE + CHILDREN	$403.76	$329.12	$388.30	$140.48	$287.70
FAMILY	$976.28	$796.06	$938.96	$339.34	$695.20
RETIREE WITHOUT MEDICARE & RE-EMPLOYED RETIREE					
ENROLLEE ONLY	$280.46	$228.66	$269.82	N/A	$199.76
ENROLLEE + 1 (SPOUSE)	$911.20	$742.94	$876.34	N/A	$553.92
ENROLLEE + 1 (CHILD)	$403.76	$329.12	$388.30	N/A	$287.70
ENROLLEE + CHILDREN	$403.76	$329.12	$388.30	N/A	$287.70
FAMILY	$917.18	$747.76	$885.06	N/A	$551.18
RETIREE WITH 1 MEDICARE					
ENROLLEE ONLY	$169.70	$138.40	$166.60	N/A	$102.04
ENROLLEE + 1 (SPOUSE)	$627.06	$511.24	$609.00	N/A	$376.86
ENROLLEE + 1 (CHILD)	$293.80	$239.48	$286.66	N/A	$176.56
ENROLLEE + CHILDREN	$293.80	$239.48	$286.66	N/A	$176.56
FAMILY	$835.52	$681.22	$810.54	N/A	$502.14
RETIREE WITH 2 MEDICARE					
ENROLLEE + 1 (SPOUSE)	$305.04	$248.70	$298.66	N/A	$183.32
FAMILY	$377.74	$307.94	$369.78	N/A	$227.02
C.O.B.R.A.					
ENROLLEE ONLY	$1,144.54	$933.14	$1,101.04	$397.88	$815.18
ENROLLEE + 1 (SPOUSE)	$2,431.20	$1,982.16	$2,338.42	$845.24	$1,731.42
ENROLLEE + 1 (CHILD)	$1,395.98	$1,138.06	$1,342.76	$485.54	$994.54
ENROLLEE + CHILDREN	$1,395.98	$1,138.06	$1,342.76	$485.54	$994.54
FAMILY	$2,564.04	$2,090.48	$2,466.14	$891.28	$1,825.90
DISABILITY C.O.B.R.A.					
ENROLLEE ONLY	$1,683.16	$1,372.30	$1,619.12	$585.10	$1,198.78
ENROLLEE + 1 (SPOUSE)	$3,575.34	$2,914.94	$3,438.92	$1,243.06	$2,546.22
ENROLLEE + 1 (CHILD)	$2,052.96	$1,673.64	$1,974.58	$714.02	$1,462.56
ENROLLEE + CHILDREN	$2,052.96	$1,673.64	$1,974.58	$714.02	$1,462.56
FAMILY	$3,770.72	$3,074.28	$3,626.76	$1,310.74	$2,685.18

For a complete list of premium rates for all employer types and at all employer participation levels, please visit info.groupbenefits.org .

NOTES:

1) The breakdown between the State Share and the Employee Share amounts shown may not be accurate for certain school board employees due to local funding that affects agency funding, which affects agency contributions. Total Premium amounts are correct for all non-risk rated agencies.
2) The breakdown between the State Share and Employee Share amounts shown for retirees without Medicare coverage is determined based upon the requirements of LA R.S. 42:851(C)(3), which supersedes the requirements of LA R.S. 42:851(E)(1).
3) All plan members who retired on or after July 1, 1997 must have Medicare Part A and Part B to qualify for reduced premium rates.

OFFICE OF GROUP BENEFITS

MEMBER-ONLY SHARE OF MONTHLY PREMIUM RATES

ALL OGB-PARTICIPATING AGENCIES

Rates for Medicare Advantage plans effective January 1, 2027 (75% employer participation level)

	Humana HMO (Region 1)	Humana HMO (Region 2)	Humana HMO (Region 3)	Humana HMO (Region 4)	Humana HMO (Region 5)
	Insured by Humana	Insured by Humana	Insured by Humana	Insured by Humana	Insured by Humana
RETIREE WITH 1 MEDICARE					
ENROLLEE ONLY	$27.98	$64.49	$55.61	$55.79	$54.90
RETIREE WITH 2 MEDICARE					
ENROLLEE + 1 (SPOUSE)	$55.96	$128.99	$111.21	$111.59	$109.80

	Humana HMO (Region 6)	Humana HMO (Region 7)	Humana HMO (Region 8)	Humana HMO (Region 9)	Peoples Health HMO-POS (All Regions)
	Insured by Humana	Insured by Humana	Insured by Humana	Insured by Humana	Insured by Peoples Health
RETIREE WITH 1 MEDICARE					
ENROLLEE ONLY	$67.68	$70.22	$70.18	$64.04	$87.50
RETIREE WITH 2 MEDICARE					
ENROLLEE + 1 (SPOUSE)	$135.36	$140.44	$140.35	$128.08	$175.00

	Blue Advantage HMO (Region 1)	Blue Advantage HMO (Region 2)	Blue Advantage HMO (Region 3)	Blue Advantage HMO (Region 4)	Blue Advantage HMO (Region 5)
	Insured by HMO Louisiana	Insured by HMO Louisiana	Insured by HMO Louisiana	Insured by HMO Louisiana	Insured by HMO Louisiana
RETIREE WITH 1 MEDICARE					
ENROLLEE ONLY	$74.50	$70.75	$70.25	$57.25	$91.75
RETIREE WITH 2 MEDICARE					
ENROLLEE + 1 (SPOUSE)	$149.00	$141.50	$140.50	$114.50	$183.50

	Blue Advantage HMO (Regions 6, 7, & 8)	Blue Advantage HMO (Region 9)
	Insured by HMO Louisiana	Insured by HMO Louisiana
RETIREE WITH 1 MEDICARE		
ENROLLEE ONLY	$77.50	$92.50
RETIREE WITH 2 MEDICARE		
ENROLLEE + 1 (SPOUSE)	$155.00	$185.00

For a complete list of premium rates for all employer types and at all employer participation levels, please visit info.groupbenefits.org .

Region 1: Orleans, Saint Bernard, Plaquemines and Jefferson Parishes
Region 2: East Baton Rouge, West Baton Rouge, Livingston, Ascension, Iberville, Pointe Coupee, East Feliciana and West Feliciana Parishes
Region 3: Lafourche, Saint John, Saint Charles, Saint James, Assumption and Terrebonne Parishes
Region 4: Lafayette, Evangeline, Saint Landry, Acadia, Saint Martin, Iberia, Vermilion and Saint Mary Parishes
Region 5: Beauregard, Allen, Calcasieu, Jefferson Davis and Cameron Parishes
Region 6: Vernon, Sabine, Natchitoches, Winn, Grant, Rapides, LaSalle, Catahoula, Concordia and Avoyelles Parishes
Region 7: Caddo, Bossier, Webster, Claiborne, Bienville, Red River and DeSoto Parishes
Region 8: Ouachita, Union, Lincoln, Jackson, Caldwell, Richland, Morehouse, Franklin, West Carroll, East Carroll, Madison and Tensas Parishes
Region 9: Washington, Saint Tammany, Saint Helena and Tangipahoa Parishes

NOTES

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Office of Group Benefits
P.O. Box 44036
Baton Rouge, LA 70804
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