

# 2017 LSU Health Plan Comparison

For the 2017 Plan Year, employees of LSU will have eight (8) health plan options from which to choose coverage.

We recommend that you review your plan options to ensure you have the coverage that best meets your needs. Below is a comparison of the benefits for each plan.

	LSU First Option 1		LSU First Option 2		Pelican HRA 1000		Pelican HSA 775		Magnolia Local		Magnolia Local Plus		Magnolia Open Access		Vantage Medical Home	
<b>Network</b>	First Choice, Verity HealthNet, Aetna ASA		First Choice, Verity HealthNet, Aetna ASA		Blue Cross Blue Shield of LA Preferred Care Providers & BCBS National Providers		Blue Cross Blue Shield of LA Preferred Care Providers & BCBS National Providers		Blue Cross Blue Shield of LA Community Blue & Blue Connect		Blue Cross Blue Shield of LA Preferred Care Providers & BCBS National Providers		Blue Cross Blue Shield of LA Preferred Care Providers & BCBS National Providers		Tier I (Affinity Health Network "AHN" and standard), Tier II, and Out-of-Network	
<b>Eligible Members</b>	Actives and Retirees		Actives and Retirees		Actives and Non-Medicare Retirees (retirement date after 3/1/15)		Actives		Actives and Non-Medicare Retirees (retirement date after 3/1/15)		Actives and Non-Medicare Retirees (retirement date after 3/1/15)		Actives and Non-Medicare Retirees (retirement date after 3/1/15)		Actives and Non-Medicare Retirees (retirement date after 3/1/15)	
<b>Plan Design</b>	<b>Deductible</b>		<b>Deductible</b>		<b>Deductible</b>		<b>Deductible</b>		<b>Deductible</b>		<b>Deductible</b>		<b>Deductible</b>		<b>Deductible</b>	
	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>
<b>Employee</b>	\$ 500	\$ 500	\$ 1,500	\$ 1,500	\$ 2,000	\$ 4,000	\$ 2,000	\$ 4,000	\$ 400	No Coverage	\$ 400	No Coverage	\$ 900	\$ 900	\$ 400	\$ 1,500
<b>Employee + Spouse</b>	\$ 750	\$ 750	\$ 2,250	\$ 2,250	\$ 4,000	\$ 8,000	\$ 4,000	\$ 8,000	\$ 800	No Coverage	\$ 800	No Coverage	\$ 1,800	\$ 1,800	\$ 800	\$ 3,000
<b>Employee + Child(ren)</b>	\$ 750	\$ 750	\$ 2,250	\$ 2,250	\$ 4,000	\$ 8,000	\$ 4,000	\$ 8,000	\$ 1,200	No Coverage	\$ 1,200	No Coverage	\$ 2,700	\$ 2,700	\$ 1,200	\$ 4,500
<b>Employee + Family</b>	\$ 1,000	\$ 1,000	\$ 3,000	\$ 3,000	\$ 4,000	\$ 8,000	\$ 4,000	\$ 8,000	\$ 1,200	No Coverage	\$ 1,200	No Coverage	\$ 2,700	\$ 2,700	\$ 1,200	\$ 4,500
					HRA dollars will reduce this amount		HSA dollars will reduce this amount									
	<b>Maximum Out of Pocket</b>		<b>Maximum Out of Pocket</b>		<b>Maximum Out of Pocket</b>		<b>Maximum Out of Pocket</b>		<b>Maximum Out of Pocket</b>		<b>Maximum Out of Pocket</b>		<b>Maximum Out of Pocket</b>		<b>Maximum Out of Pocket</b>	
<b>Employee</b>	\$ 3,500	\$ 6,500	\$ 4,500	\$ 7,500	\$ 5,000	\$ 10,000	\$ 5,000	\$ 10,000	\$ 2,500	No Coverage	\$ 2,500	No Coverage	\$ 2,500	\$ 3,700	\$ 2,500	Unlimited
<b>Employee + Spouse</b>	\$ 5,250	\$ 9,750	\$ 6,750	\$ 11,250	\$ 10,000	\$ 20,000	\$ 10,000	\$ 20,000	\$ 5,000	No Coverage	\$ 5,000	No Coverage	\$ 5,000	\$ 7,500	\$ 5,000	Unlimited
<b>Employee + Child(ren)</b>	\$ 5,250	\$ 9,750	\$ 6,750	\$ 11,250	\$ 10,000	\$ 20,000	\$ 10,000	\$ 20,000	\$ 7,500	No Coverage	\$ 7,500	No Coverage	\$ 7,500	\$ 11,250	\$ 7,500	Unlimited
<b>Employee + Family</b>	\$ 7,000	\$ 13,000	\$ 9,000	\$ 15,000	\$ 10,000	\$ 20,000	\$ 10,000	\$ 20,000	\$ 7,500	No Coverage	\$ 7,500	No Coverage	\$ 7,500	\$ 11,250	\$ 7,500	Unlimited
	MOP includes Deductible		MOP includes Deductible													
	<b>State Funding</b>		<b>State Funding</b>		<b>State Funding</b>		<b>State Funding</b>		<b>State Funding</b>		<b>State Funding</b>		<b>State Funding</b>		<b>State Funding</b>	
<b>Employee</b>	\$1,000		\$1,000		\$1,000		\$775		Not Available		Not Available		Not Available		Not Available	
<b>Employee + Spouse</b>	\$1,500		\$1,500		\$2,000		\$775									
<b>Employee + Child(ren)</b>	\$1,500		\$1,500		\$2,000		\$775									
<b>Employee + Family</b>	\$2,000		\$2,000		\$2,000		\$775									
	Pharmacy and Medical Expenses. Remaining balance will be rolled over, up to a maximum amount		Pharmacy and Medical Expenses. Remaining balance will be rolled over, up to a maximum amount		Funding not applicable to Pharmacy Expenses		\$200, plus up to \$575 more dollar-for-dollar match of employee contributions									
<b>Physicians' Services</b>	<b>Coverage</b>		<b>Coverage</b>		<b>Coverage</b>		<b>Coverage</b>		<b>Coverage</b>		<b>Coverage</b>		<b>Coverage</b>		<b>Coverage</b>	
	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>
<b>Primary Care Physician or Specialist</b>	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after a \$25 PCP or \$50 SPC co-pay per visit	No Coverage	100% coverage after a \$25 PCP or \$50 SPC co-pay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a \$10 AHN/\$20 PCP or \$35 AHN/\$45 SPC co-pay per visit	50% coverage; subject to Out-of-Network deductible
<b>Maternity Care</b>	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after a \$90 co-pay per pregnancy	No Coverage	100% coverage after a \$90 co-pay per pregnancy	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a \$10 AHN/\$20 co-pay per pregnancy	50% coverage; subject to Out-of-Network deductible
<b>Physician Services Furnished in a Hospital</b>	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; subject to deductible	No Coverage	100% coverage; subject to deductible	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; subject to Tier I deductible	50% coverage; subject to Out-of-Network deductible

Physicians' Services	LSU First Option 1 Coverage		LSU First Option 2 Coverage		Pelican HRA 1000 Coverage		Pelican HSA 775 Coverage		Magnolia Local Coverage		Magnolia Local Plus Coverage		Magnolia Open Access Coverage		Vantage HMO Coverage	
	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network
Preventive Care	100% coverage; NOT subject to HRA or deductible	100% of MRC*, subject to deductible	100% coverage; NOT subject to HRA or deductible	100% of MRC*, subject to deductible	100% coverage; NOT subject to deductible	100% of fee schedule amount Plan participant pays the difference between the billed amount and the fee schedule amount; NOT subject to deductible	100% coverage; NOT subject to deductible	100% of fee schedule amount Plan participant pays the difference between the billed amount and the fee schedule amount; NOT subject to deductible	100% coverage; NOT subject to deductible	No Coverage	100% coverage; NOT subject to deductible	No Coverage	100% coverage; NOT subject to deductible	70% coverage; subject to deductible	100% coverage; NOT subject to deductible	50% coverage; subject to Out-of-Network deductible
Physician Services for ER Care	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	90% of MRC*; subject to deductible	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	90% of MRC*; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible	100% coverage; subject to deductible	100% coverage; subject to deductible	100% coverage; subject to deductible	100% coverage; subject to deductible	90% coverage; subject to deductible	90% coverage; subject to deductible	100% coverage; subject to Tier I deductible	50% coverage; subject to Out-of-Network deductible
Outpatient Surgery/Services (billed as outpatient surgery at a facility)	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; subject to deductible	No Coverage	100% coverage; subject to deductible	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; subject to Tier I deductible	50% coverage; subject to Out-of-Network deductible
Hospital Services	Coverage		Coverage		Coverage		Coverage		Coverage		Coverage		Coverage		Coverage	
Inpatient Services	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network
Inpatient Services	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; after a \$100 co-pay per day. \$300 per admission max	No Coverage	100% coverage; after a \$100 co-pay per day. \$300 per admission max	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible + \$50 co-pay per day (days 1-5)	100% coverage after a \$50 AHN/\$100 co-pay per day max \$150 AHN/\$300 per admission; not subject to deductible	50% coverage; subject to Out-of-Network deductible
Outpatient Surgery/Services (billed at a hospital)	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; after a \$100 facility co-pay per visit	No Coverage	100% coverage; after a \$100 facility co-pay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a \$50 AHN/\$100 co-pay	50% coverage; subject to Out-of-Network deductible
Emergency Room Care	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	90% of MRC*; subject to deductible	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	90% of MRC*; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible	100% coverage after \$150 co-pay per visit; waived if admitted	100% coverage after \$150 co-pay per visit; waived if admitted	100% coverage after \$150 co-pay per visit; waived if admitted	100% coverage after \$150 co-pay per visit; waived if admitted	90% coverage after \$150 co-pay; waived if admitted.	90% coverage after \$150 co-pay; waived if admitted.	100% coverage after \$150 co-pay per visit; waived if admitted.	100% coverage after \$150 co-pay per visit; not subject to deductible
Behavioral Health	Coverage		Coverage		Coverage		Coverage		Coverage		Coverage		Coverage		Coverage	
Mental Health and Substance Abuse - Inpatient	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network
Mental Health and Substance Abuse - Inpatient	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after \$100 co-pay per day. \$300 per admission max	No Coverage	100% coverage after \$100 co-pay per day. \$300 per admission max	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible + \$50 co-pay per day (days 1-5)	100% coverage after a \$50 AHN/\$100 co-pay per day max, \$150 AHN/\$300 per admission; not subject to deductible	50% coverage; subject to Out-of-Network deductible
Mental Health and Substance Abuse - Outpatient	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after \$25 co-pay per visit	No Coverage	100% coverage after \$25 co-pay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a \$10 AHN/\$20 PCP or \$35 AHN/\$45 SPC co-pay per visit	50% coverage; subject to Out-of-Network deductible

Other Services	LSU First Option 1 Coverage		LSU First Option 2 Coverage		Pelican HRA 1000 Coverage		Pelican HSA 775 Coverage		Magnolia Local Coverage		Magnolia Local Plus Coverage		Magnolia Open Access Coverage		Vantage HMO Coverage	
	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network
Outpatient Short-Term Rehabilitation Services (PT/ST/OT/Other)	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; after \$25 co-pay per visit	No Coverage	100% coverage; after a \$25 co-pay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a \$10 AHN/\$20 co-pay per visit	50% coverage; subject to Out-of-Network deductible
Routine Vision Exam	100% coverage; NOT subject to HRA or deductible	100% of MRC*, subject to deductible	100% coverage; NOT subject to HRA or deductible	100% of MRC*, subject to deductible	No Coverage		No Coverage		No Coverage		No Coverage		No Coverage		100% coverage; after a \$35 AHN/\$45 co-pay	50% coverage; subject to Out-of-Network deductible
Other Services	Coverage		Coverage		Coverage		Coverage		Coverage		Coverage		Coverage		Coverage	
	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network
Urgent Care Center	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; after \$50 co-pay per visit	No Coverage	100% coverage; after \$50 co-pay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after \$50 co-pay per visit	50% coverage; subject to Out-of-Network deductible
Home Health Care Services	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; subject to deductible	No Coverage	100% coverage; subject to deductible	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; subject to Tier I deductible	No Coverage
Hospice Care	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; subject to deductible	No Coverage	100% coverage; subject to deductible	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage; subject to Tier I deductible	50% coverage; subject to Out-of-Network deductible
Durable Medical Equipment (DME)	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	First Choice: 100% after HRA Verity/Aetna: 90% coverage; subject to deductible	60% of MRC*; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage of the first \$5,000 allowable; 100% in excess of \$5,000 per plan year; subject to deductible	No Coverage	80% coverage of the first \$5,000 allowable; 100% in excess of \$5,000 per plan year; subject to deductible	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	80% coverage of the first \$5,000 allowable; 100% in excess of \$5,000 per plan year; subject to deductible	50% coverage; subject to Out-of-Network deductible
Pharmacy	Coverage You Pay		Coverage You Pay		Coverage You Pay		Coverage You Pay		Coverage You Pay		Coverage You Pay		Coverage You Pay		Coverage You Pay	
Tier 1 - Generic	100% after HRA		100% after HRA		50% up to \$30		\$10; subject to deductible		50% up to \$30		50% up to \$30		50% up to \$30		Preferred Generics - \$5 co-pay Non Preferred Generics - \$20 co-pay	
Tier 2 - Preferred Brand	\$40; subject to deductible		\$40; subject to deductible		50% up to \$55		\$25; subject to deductible		50% up to \$55		50% up to \$55		50% up to \$55		\$50 co-pay	
Tier 3 - Non-Preferred Brand	\$40; subject to deductible		\$40; subject to deductible		65% up to \$80		\$50; subject to deductible		65% up to \$80		65% up to \$80		65% up to \$80		\$80 co-pay	
Tier 4 - Specialty	\$150; subject to deductible		\$150; subject to deductible		50% up to \$80		\$50; subject to deductible		50% up to \$80		50% up to \$80		50% up to \$80		\$150 co-pay	
90 day supply for maintenance drugs from mail order OR at participating 90 day retail network pharmacies	30-day supply for 1 co-pay; 90-day supply for 3 co-pays.		30-day supply for 1 co-pay; 90-day supply for 3 co-pays.		2.5 times the cost of your applicable co-pay		Applicable co-pay; Maintenance drugs not subject to deductible		2.5 times the cost of your applicable co-pay		2.5 times the cost of your applicable co-pay		2.5 times the cost of your applicable co-pay		Preferred Generics \$0 AHN co-pay; 30-day supply for 1 co-pay; 60-day supply for 2 co-pays; 90-day supply for 3 co-pays	
<b>After the out-of-pocket threshold of \$1,500 is met:</b>																
Tier 1 - Generic	N/A		N/A		\$0 co-pay		N/A		\$0 co-pay		\$0 co-pay		\$0 co-pay		N/A	
Tier 2 - Preferred Brand	N/A		N/A		\$20 co-pay		N/A		\$20 co-pay		\$20 co-pay		\$20 co-pay		N/A	
Tier 3 - Non-Preferred Brand	N/A		N/A		\$40 co-pay		N/A		\$40 co-pay		\$40 co-pay		\$40 co-pay		N/A	
Tier 4 - Specialty	N/A		N/A		\$40 co-pay		N/A		\$40 co-pay		\$40 co-pay		\$40 co-pay		N/A	

\*Maximum Reimbursable Charge

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

This comparison chart is a summary of plan features and is presented for general information only. It is not a guarantee of coverage. For full details of any plan listed, refer to the Plan Document.

LSU is not responsible for the accuracy of this information.