2023 LSU Health Plan Comparison

For the 2023 Plan Year, active employees of LSU have seven (7) health plan options to choose from. 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. We recommend that you review your plan options to ensure you have the coverage that best meets your needs.

	LSU First			Pelican HRA 1000		Pelican HSA 775		Magnolia Local		Magnolia Local Plus		Magnolia Open Access		Vantage Medical Home	
Network	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		Affinity Health Network "AHN" and standard In-Network and Out-of-Network	
Eligible Members	Actives and Non-Medicare 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)	
Plan Design	**Deductible**			**Deductible**		**Deductible**		**Deductible**		**Deductible**		**Deductible**		**Deductible**	
	First Choice	**In-Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Employee	$0	$500	$500	$2,000	$4,000	$2,000	$4,000	$400	No Coverage	$400	No Coverage	$900	$900	$400	$2,000
Employee + Spouse	$0	$750	$750	$4,000	$8,000	$4,000	$8,000	$800	No Coverage	$800	No Coverage	$1,800	$1,800	$800	$4,000
Employee + Child(ren)	$0	$750	$750	$4,000	$8,000	$4,000	$8,000	$1,200	No Coverage	$1,200	No Coverage	$2,700	$2,700	$1,200	$6,000
Employee + Family	$0	$1,000	$1,000	$4,000	$8,000	$4,000	$8,000	$1,200	No Coverage	$1,200	No Coverage	$2,700	$2,700	$1,200	$6,000
	Deductible applies to covered medical services only; does not apply to pharmacy			HRA dollars will reduce this amount		HSA dollars will reduce this amount									
	Maximum Out of Pocket			**Maximum Out of Pocket**		**Maximum Out of Pocket**		**Maximum Out of Pocket**		**Maximum Out of Pocket**		**Maximum Out of Pocket**		**Maximum Out of Pocket**	
Employee	$4,500 Medical; $4,500 Drug		Unlimited	$5,000	$10,000	$5,000	$10,000	$2,500	No Coverage	$3,500	No Coverage	$3,500	$4,700	$3,500	Unlimited
Employee + Spouse	$6,750 Medical; $6,750 Drug		Unlimited	$10,000	$20,000	$10,000	$20,000	$5,000	No Coverage	$6,000	No Coverage	$6,000	$8,500	$6,000	Unlimited
Employee + Child(ren)	$6,750 Medical; $6,750 Drug		Unlimited	$10,000	$20,000	$10,000	$20,000	$7,500	No Coverage	$8,500	No Coverage	$8,500	$12,250	$8,500	Unlimited
Employee + Family	$9,000 Medical; $9,000 Drug		Unlimited	$10,000	$20,000	$10,000	$20,000	$7,500	No Coverage	$8,500	No Coverage	$8,500	$12,250	$8,500	Unlimited
	Medical includes HRA and Deductible														
	State Funding			**State Funding**		**State Funding**		**State Funding**		**State Funding**		**State Funding**		**State Funding**	
Employee	$500			$1,000		$200 initial yearly deposit if HSA account opened; up to an additional $575 dollar for dollar match		Not Available		Not Available		Not Available		Not Available	
Employee + Spouse	$750			$2,000											
Employee + Child(ren)	$750			$2,000											
Employee + Family	$1,000			$2,000											
	Funding not applicable to pharmacy expenses			Funding not applicable to pharmacy expenses											
Physicians' Services	**Coverage**			**Coverage**		**Coverage**		**Coverage**		**Coverage**		**Coverage**		**Coverage**	
	First Choice	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**
Primary Care Physician or Specialist Office Visit	100% coverage after HRA	80% coverage; subject to deductible	60% coverage; subject to deductible and MAC*	80% coverage; subject to deductible	60% coverage, subject to deductible	80% coverage, subject to deductible	60% coverage, subject to deductible	100% coverage after a $25 PCP or $50 SPC copay per visit	No Coverage	100% coverage after a $25 PCP or $50 SPC copay per visit	No Coverage	90% coverage; subject to deductible	70% coverage, subject to deductible	100% coverage after a $20 AHN/$40 PCP or $45 AHN/$65 SPC copay per visit	50% coverage; subject to Out-of-Network deductible
Maternity Care	100% coverage after HRA	80% coverage; subject to deductible	60% coverage; subject to deductible and MAC*	80% coverage; subject to deductible	60% coverage, subject to deductible	80% coverage, subject to deductible	60% coverage, subject to deductible	100% coverage after a $90 copay per pregnancy	No Coverage	100% coverage after a $90 copay per pregnancy	No Coverage	90% coverage; subject to deductible	70% coverage, subject to deductible	100% coverage after a $20 AHN/$40 copay per pregnancy	50% coverage; subject to Out-of-Network deductible
Physician Services Furnished in a Hospital	100% coverage after HRA	80% coverage; subject to deductible	60% coverage; subject to deductible and MAC*	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 In-Network deductible	50% coverage; subject to Out-of-Network deductible
Preventive Care	100% coverage; NOT subject to HRA	100% coverage; NOT subject to HRA or deductible	100% coverage; subject to MAC*	100% coverage; NOT subject to deductible	100% of fee schedule amount. Member 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. Member 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 In-Network deductible	50% coverage; subject to Out-of-Network deductible

Physicians' Services	LSU First			Pelican HRA 1000		Pelican HSA 775		Magnolia Local		Magnolia Local Plus		Magnolia Open Access		Vantage HMO	
	Coverage			Coverage		Coverage		Coverage		Coverage		Coverage		Coverage	
	First Choice	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Physician Services for ER Care	100% coverage after HRA	80% coverage; subject to deductible	80% coverage; subject to deductible and MAC*	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 In-Network deductible	100% coverage; subject to In-Network deductible
Outpatient Surgery/Services (billed as outpatient surgery at a facility)	100% coverage after HRA	80% coverage; subject to deductible	60% coverage; subject to deductible and MAC*	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 In-Network deductible	50% coverage; subject to Out-of-Network deductible
Hospital Services	Coverage			Coverage		Coverage		Coverage		Coverage		Coverage		Coverage	
	First Choice	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Inpatient Services	100% coverage after HRA	80% coverage; subject to deductible	60% coverage; subject to deductible and MAC*	80% coverage; subject to deductible	60% coverage, subject to deductible	80% coverage; subject to deductible	60% coverage, subject to deductible	100% coverage; after a $100 copay per day; $300 per admission max	No Coverage	100% coverage; after a $100 copay per day; $300 per admission max	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible + $50 copay per day (days 1-5)	100% coverage after a $100 AHN/$250 copay per day max $300 AHN/$750 per admission	50% coverage; subject to Out-of-Network deductible
Outpatient Surgery/Services (billed at a hospital)	$300 penalty if performed at hospital facility; 100% coverage after HRA	$300 penalty if performed at hospital facility; 80% coverage; subject to deductible	$300 penalty if performed at hospital facility; 60% coverage; subject to deductible and MAC*	80% coverage; subject to deductible	60% coverage, subject to deductible	80% coverage; subject to deductible	60% coverage, subject to deductible	100% coverage; after a $100 facility copay per visit	No Coverage	100% coverage; after a $100 facility copay per visit	No Coverage	90% coverage; subject to deductible	70% coverage, subject to deductible	100% coverage after a $100 AHN/$250 copay	50% coverage; subject to Out-of-Network deductible
Emergency Room Care	$150 copay; copay waived if admitted; 100% coverage after HRA	80% coverage after $150 copay; subject to deductible; copay waived if admitted	80% coverage after $150 copay; subject to deductible and MAC*; copay waived if admitted	80% coverage; subject to deductible	80% coverage, subject to deductible	80% coverage; subject to deductible	80% coverage, subject to deductible	100% coverage after $200 copay per visit; waived if admitted	100% coverage after $200 copay per visit; waived if admitted	100% coverage after $200 copay per visit; waived if admitted	100% coverage after $200 copay per visit; waived if admitted	90% coverage after $200 copay per visit; waived if admitted	90% 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
Behavioral Health	Coverage			Coverage		Coverage		Coverage		Coverage		Coverage		Coverage	
	First Choice	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Mental Health and Substance Abuse - Inpatient	100% coverage after HRA	80% coverage; subject to deductible	60% coverage; subject to deductible and MAC*	80% coverage; subject to deductible	60% coverage, subject to deductible	80% coverage; subject to deductible	60% coverage, subject to deductible	100% coverage after $100 copay per day; $300 per admission max	No Coverage	100% coverage after $100 copay per day; $300 per admission max	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible + $50 copay per day (days 1-5)	100% coverage after a $100 AHN/$250 copay per day, max $300 AHN/$750 per admission	50% coverage; subject to Out-of-Network deductible
Mental Health and Substance Abuse - Outpatient	100% coverage after HRA	80% coverage; subject to deductible	60% coverage; subject to deductible and MAC*	80% coverage; subject to deductible	60% coverage, subject to deductible	80% coverage; subject to deductible	60% coverage, subject to deductible	100% coverage after $25 copay per visit	No Coverage	100% coverage after $25 copay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after a $20 AHN/$40 PCP copay per visit	50% coverage; subject to Out-of-Network deductible

Other Services	LSU First			Pelican HRA 1000		Pelican HSA 775		Magnolia Local		Magnolia Local Plus		Magnolia Open Access		Vantage HMO	
	Coverage			Coverage		Coverage		Coverage		Coverage		Coverage		Coverage	
	First Choice	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Outpatient Short-Term Rehabilitation Services (PT/ST/OT/Other)	100% coverage after HRA	80% coverage; subject to deductible	60% coverage; subject to deductible and MAC*	80% coverage; subject to deductible	60% coverage, subject to deductible	80% coverage; subject to deductible	60% coverage, subject to deductible	100% coverage; after $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	100% coverage after a $20 AHN/$40 copay per visit	50% coverage; subject to Out-of-Network deductible
Routine Vision Exam	100% coverage; NOT subject to HRA or deductible	100% coverage; NOT subject to HRA or deductible	100% coverage; subject to MAC*	No Coverage		No Coverage		No Coverage		No Coverage		No Coverage		Exam: $45 AHN/$65 copay per visit	50% coverage; subject to Out-of-Network deductible
Urgent Care Center	100% coverage after HRA	80% coverage; subject to deductible	60% coverage; subject to deductible and MAC*	80% coverage; subject to deductible	60% coverage, subject to deductible	80% coverage; subject to deductible	60% coverage, subject to deductible	100% coverage; after $50 copay per visit	No Coverage	100% coverage; after $50 copay per visit	No Coverage	90% coverage; subject to deductible	70% coverage; subject to deductible	100% coverage after $50 copay per visit	50% coverage; subject to Out-of-Network deductible
Home Health Care Services and Hospice Care	100% coverage after HRA	80% coverage; subject to deductible	60% coverage; subject to deductible and MAC*	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 In-Network deductible	No Coverage
Durable Medical Equipment (DME)	100% coverage after HRA	80% coverage; subject to deductible	60% coverage; subject to deductible and MAC*	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	LSU First	Pelican HRA 1000	Pelican HSA 775	Magnolia Local	Magnolia Local Plus	Magnolia Open Access	Vantage HMO
	You Pay	You Pay	You Pay	You Pay	You Pay	You Pay	You Pay
Tier 1 - Generic	$0; Covered at 100%	50% up to $30	$10; subject to deductible	50% up to $30	50% up to $30	50% up to $30	Preferred Generics: $0 AHN/$15 copay Non-Preferred Generics: $40 copay
Tier 2 - Preferred Brand	20% up to $150	50% up to $55	$25; subject to deductible	50% up to $55	50% up to $55	50% up to $55	$75 copay
Tier 3 - Non-Preferred Brand	20% up to $150	65% up to $80	$50; subject to deductible	65% up to $80	65% up to $80	65% up to $80	$100 copay
Tier 4 - Specialty	20% up to $150	50% up to $80	$50; subject to deductible	50% up to $80	50% up to $80	50% up to $80	$150 copay
90 day supply for maintenance drugs from mail order or at participating retail pharmacies	3 times the cost of your applicable coinsurance	2.5 times the cost of your applicable copay	Applicable copay; Maintenance drugs not subject to deductible	2.5 times the cost of your applicable copay	2.5 times the cost of your applicable copay	2.5 times the cost of your applicable copay	Preferred Generics $0 AHN copay; Tiers 1-4: 100-day supply for 3 copays
After the out-of-pocket threshold of $1,500 is met:							
Tier 1 - Generic	Same cost as above	$0 copay	Same cost as above	$0 copay	$0 copay	$0 copay	Same cost as above
Tier 2 - Preferred Brand		$20 copay		$20 copay	$20 copay	$20 copay	
Tier 3 - Non-Preferred Brand		$40 copay		$40 copay	$40 copay	$40 copay	
Tier 4 - Specialty		$40 copay		$40 copay	$40 copay	$40 copay	

*Subject to Maximum Allowable Charge (MAC)

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, please refer to the Plan Document.