

2020 LSU Health Plan Comparison

For the 2020 Plan Year, active employees of LSU will have seven (7) 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		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		Tier I (Affinity Health Network "AHN" and standard), Tier II, 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	
	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network
Employee	\$ 500	\$ 500	\$ 2,000	\$ 4,000	\$ 2,000	\$ 4,000	\$ 400	No Coverage	\$ 400	No Coverage	\$ 900	\$ 900	\$ 400	\$ 1,500
Employee + Spouse	\$ 750	\$ 750	\$ 4,000	\$ 8,000	\$ 4,000	\$ 8,000	\$ 800	No Coverage	\$ 800	No Coverage	\$ 1,800	\$ 1,800	\$ 800	\$ 3,000
Employee + Child(ren)	\$ 750	\$ 750	\$ 4,000	\$ 8,000	\$ 4,000	\$ 8,000	\$ 1,200	No Coverage	\$ 1,200	No Coverage	\$ 2,700	\$ 2,700	\$ 1,200	\$ 4,500
Employee + Family	\$ 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	\$ 4,500
			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	\$ 7,500	\$ 5,000	\$ 10,000	\$ 5,000	\$ 10,000	\$ 2,500	No Coverage	\$ 3,500	No Coverage	\$ 3,500	\$ 3,700	\$ 2,500	Unlimited
Employee + Spouse	\$ 6,750	\$ 11,250	\$ 10,000	\$ 20,000	\$ 10,000	\$ 20,000	\$ 5,000	No Coverage	\$ 6,000	No Coverage	\$ 6,000	\$ 7,500	\$ 5,000	Unlimited
Employee + Child(ren)	\$ 6,750	\$ 11,250	\$ 10,000	\$ 20,000	\$ 10,000	\$ 20,000	\$ 7,500	No Coverage	\$ 8,500	No Coverage	\$ 8,500	\$ 11,250	\$ 7,500	Unlimited
Employee + Family	\$ 9,000	\$ 15,000	\$ 10,000	\$ 20,000	\$ 10,000	\$ 20,000	\$ 7,500	No Coverage	\$ 8,500	No Coverage	\$ 8,500	\$ 11,250	\$ 7,500	Unlimited
	Includes HRA and Deductible													
	State Funding		State Funding		State Funding		State Funding		State Funding		State Funding		State Funding	
Employee	\$1,000		\$1,000		\$775		Not Available		Not Available		Not Available		Not Available	
Employee + Spouse	\$1,500		\$2,000		\$775									
Employee + Child(ren)	\$1,500		\$2,000		\$775									
Employee + Family	\$2,000		\$2,000		\$775									
	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									
Physicians' Services	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
Primary Care Physician or Specialist	First Choice: 100% coverage after HRA Verity/Aetna: 80% coverage; subject to deductible	60% coverage; subject to deductible and MRC*	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
Maternity Care	First Choice: 100% coverage after HRA Verity/Aetna: 80% coverage; subject to deductible	60% coverage; subject to deductible and MRC*	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
Physician Services Furnished in a Hospital	First Choice: 100% coverage after HRA Verity/Aetna: 80% coverage; subject to deductible	60% coverage; subject to deductible and MRC*	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
Preventive Care	100% coverage; NOT subject to HRA or deductible	100% coverage; subject to MRC*	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

Physicians' Services	LSU First Option 1 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
Physician Services for ER Care	First Choice: 100% coverage after HRA Verity/Aetna: 80% coverage; subject to deductible	60% coverage; subject to deductible and MRC*	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% coverage after HRA Verity/Aetna: 80% coverage; subject to deductible	60% coverage; subject to deductible and MRC*	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	
	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% coverage after HRA Verity/Aetna: 80% coverage; subject to deductible	100% coverage; subject to MRC*	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% coverage after HRA Verity/Aetna: 80% coverage; subject to deductible	60% coverage; subject to deductible and MRC*	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 \$150 co-pay Verity/Aetna: 80% coverage after \$150 co-pay; subject to deductible; co-pay waived if admitted	80% coverage after \$150 co-pay; subject to deductible and MRC*; co-pay 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 \$150 co-pay per visit; waived if admitted	100% coverage after \$150 co-pay per visit; waived if admitted	100% coverage after \$200 co-pay per visit; waived if admitted	100% coverage after \$200 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	
	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% coverage after HRA Verity/Aetna: 80% coverage; subject to deductible	60% coverage; subject to deductible and MRC*	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% coverage after HRA Verity/Aetna: 80% coverage; subject to deductible	60% coverage; subject to deductible and MRC*	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		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
Outpatient Short-Term Rehabilitation Services (PT/ST/OT/Other)	First Choice: 100% coverage after HRA Verity/Aetna: 80% coverage; subject to deductible	60% coverage; subject to deductible and MRC*	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% coverage; subject to MRC*	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
Urgent Care Center	First Choice: 100% coverage after HRA Verity/Aetna: 80% coverage; subject to deductible	60% coverage; subject to deductible and MRC*	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% coverage after HRA Verity/Aetna: 80% coverage; subject to deductible	60% coverage; subject to deductible and MRC*	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% coverage after HRA Verity/Aetna: 80% coverage; subject to deductible	60% coverage; subject to deductible and MRC*	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% coverage after HRA Verity/Aetna: 80% coverage; subject to deductible	60% coverage; subject to deductible and MRC*	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 Option 1 Coverage You Pay		Pelican HRA 1000 Coverage You Pay		Pelican HSA 775 Coverage You Pay		Magnolia Local Coverage You Pay		Magnolia Local Plus Coverage You Pay		Magnolia Open Access Coverage You Pay		Vantage HMO Coverage You Pay	
Tier 1 - Generic	\$0 after HRA; Covered at 100%		50% up to \$30		\$10; subject to deductible		50% up to \$30		50% up to \$30		50% up to \$30		Preferred - \$5 co-pay Non Preferred - \$20 co-pay	
Tier 2 - Preferred Brand	20% up to \$150; 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	20% up to \$150; 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	20% up to \$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.		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	
After the out-of-pocket threshold of \$1,500 is met:														
Tier 1 - Generic	N/A		\$0 co-pay		N/A		\$0 co-pay		\$0 co-pay		\$0 co-pay		N/A	
Tier 2 - Preferred Brand	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		\$40 co-pay		N/A		\$40 co-pay		\$40 co-pay		\$40 co-pay		N/A	
Tier 4 - Specialty	N/A		\$40 co-pay		N/A		\$40 co-pay		\$40 co-pay		\$40 co-pay		N/A	

*Subject to Maximum Reimbursable Charge

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.