2019 Annual Enrollment
Human Resources Training
Changes for 2019

Coverage for Dependent Children:
- Changes have been made to the eligibility for dependents

<table>
<thead>
<tr>
<th>Eligibility Determination</th>
<th>Natural or Adopted/Placed Children</th>
<th>Stepchildren</th>
<th>Grandchildren (Unmarried; Resides with and in legal custody of Enrollee)</th>
<th>Court-ordered Legal Custody/Guardianship (Unmarried)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered until they reach age 26</td>
<td>Covered until they reach age 26¹</td>
<td>Covered until age 26²</td>
<td>Covered until age 26²</td>
<td>Covered until age 18²</td>
</tr>
</tbody>
</table>

- Grandchildren may be covered if the grandchild is unmarried, resides with the enrollee and is in legal custody of the enrollee. Coverage will continue until age 26.
- Dependents who are unmarried and in court-ordered legal custody/guardianship of the enrollee will be covered until age 18.

¹ Per the plan document, stepchildren are eligible for coverage as a non-spouse dependent up to age 26 as long as the stepchild’s natural parent is living and is married to the primary enrollee.

² Authority is La. R.S. 48:808 (E)
Changes for 2019 (continued)

Coverage for Dependent Children:

- **Dependents who are incapable of self-sustaining employment by reason of mental or physical impairment**
  - A covered Child under age 26 who is or becomes incapable of self-sustaining employment may be eligible to continue coverage as an over-age dependent, if the Office of Group Benefits receives the required medical documents verifying the child’s incapacity before he or she reaches age 26. (La. R.S. 42:808(F))

- **Life Insurance**

- **Retiree 100**
  - Effective 1/1/2019, the monthly premium for the Retiree 100 plan will increase from $39 per-enrollee per-month to $81 per-enrollee per month.
  - This plan is only available to Medicare retirees enrolled in the Magnolia Open Access plan.
2019 Annual Enrollment

IMPORTANT FACTS

• NO PREMIUM INCREASES ON HEALTH PLANS

• LaGov active employees (excluding rehired retirees) will be allowed to enroll through LEO or Human Resources.

• LaGov rehired retirees must enroll through Human Resources.

• Non-LaGov active employees will be allowed to enroll through the OGB annual enrollment portal or Human Resources.

• Members must print or download their own confirmation page from the web portal.

• Members enrolled in the HSA MUST elect or re-elect their HSA contributions for the 2019 plan year.

• Members enrolled in an FSA MUST elect or re-elect to participate for the 2019 plan year.
HR Liaison’s Responsibilities

Human Resources representatives will have several responsibilities during this year’s annual enrollment period:

• Assisting OGB in sharing enrollment process and eligibility information with your active employees.

• Answering general questions related to plan options and annual enrollment.

• Collect appropriate forms and make changes in eEnrollment or the LaGov HCM benefits module.

• Enrolling active employees who are making changes to their level of coverage, adding/dropping dependents or changing plans, as needed, through the current eEnrollment system or LaGov HCM benefits module.

• Non-LaGov agencies will utilize eEnrollment for active employees who are making changes to their level of coverage, adding/dropping dependents, changing plans, enrolling in/terming coverage, enrolling in FSA, etc.
Timeline

- Oct 1 – OGB Annual Enrollment Begins
- Nov 15 – OGB Annual Enrollment Ends
- Nov 22 – Deadline for agencies to enter all plan changes made during Annual Enrollment in the eEnrollment system (Non-LaGov) and in the LaGov HCM benefits module. *(Late applications will not be accepted)*
- Jan 1 – 2019 plan year begins

*This includes HSA and FSA programs*
Non-LaGov eEnrollment Key-In Dates

• Health coverage increases must be keyed into eEnrollment between the dates of November 15, 2018 to December 14, 2018 for an effective date of January 1, 2019.
  o EE > EE+Child
  o EE > EE+Spouse
  o Family

• Health coverage decreases or cancellation of coverage must be keyed into eEnrollment between the dates of December 1, 2018 to December 31, 2018 for an effective date of January 1, 2019.
  o Family Coverage > EE + Child, EE+Spouse, or EE Only
  o EE+Spouse > EE Only
  o EE+Child > EE Only
  o Cancellation of Health Coverage

This information can also be located in eEnrollment in the Annual Enrollment Key-In Deadlines area.
2019 Enrollment Process
# How to Enroll

Active employees may enroll or make changes through one of the following options:

<table>
<thead>
<tr>
<th>Active Employees</th>
<th>OGB Annual Enrollment Portal (Non-LaGov)</th>
<th>LEO Enrollment Application (LaGov)</th>
<th>Human Resources (LaGov &amp; Non-LaGov)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enroll in a new health plan with the same covered dependents as 2018</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Enroll in a health plan with different or new covered dependents than 2018</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Elect or re-elect HSA contributions</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>(Re-elect)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elect or re-elect FSA contributions</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Apply for life insurance</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Discontinue/Waive OGB health life</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Discontinue insurance coverage</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>
How to Enroll

Retired employees may make changes to their OGB coverage through one of the options listed below:

<table>
<thead>
<tr>
<th>Retirees</th>
<th>OGB Annual Enrollment Portal</th>
<th>Annual Enrollment Form</th>
<th>OGB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enroll in a health plan with the same covered dependents as 2018</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Enroll in a health plan with different or new covered dependents than 2018</td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>*Discontinue OGB coverage</td>
<td></td>
<td></td>
<td>✔</td>
</tr>
</tbody>
</table>

*If a retired employee discontinues their OGB coverage, they cannot come back.
LaGov Employees Annual Enrollment Application

Eligible LaGov paid active employees* wishing to change, waive, or enroll in health or life insurance and enroll in FSA or HSA deductions for 2019 should do so through Louisiana Employees Online (LEO)

To Enroll:

• Log into LEO
• Select the My Benefits tab
• Click on the Annual Enrollment Link
• Make your selection for health/life
• Select your FSA and/or HSA deduction

*rehired retirees will need to contact HR for any benefit changes
OGB Annual Enrollment Portal

Non-LaGov active employees & retirees, and LaGov retirees wishing to change health plans with the same covered dependents as their 2018 plan should use the annual enrollment portal to make their 2019 selection.

To enroll using the OGB annual enrollment portal:

• Follow the links from the OGB homepage – info.groupbenefits.org – to the annual enrollment portal
• Log into the portal by entering your last name, date of birth, the last four digits of your Social Security Number and your zip code
• Confirm your contact information
• Make plan selection
• Enter HSA and/or FSA contributions (where applicable)
• Review selections and click “Confirm” to save changes and view confirmation page; click “Change” to revise your selections.
• Print / Save pdf confirmation and click “Logout” to exit the portal; click “Change” to revise your selections.

NOTE: Adding and removing dependents cannot be completed through the web portal; FSA and HSA contributions **MUST** be renewed annually.
### Meeting Schedule

**Active Employees & Non-Medicare Retirees**

<table>
<thead>
<tr>
<th>DATE</th>
<th>LOCATION</th>
<th>START TIMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2</td>
<td>West Monroe Civic Center 901 Ridge Ave., West Monroe, LA 71291</td>
<td>9:00 AM or 2:00 PM</td>
</tr>
<tr>
<td>October 9</td>
<td>Houma - Terrebonne Civic Center 346 Civic Center Blvd., Houma, LA 70360</td>
<td>9:00 AM or 2:00 PM</td>
</tr>
<tr>
<td>October 10</td>
<td>University of New Orleans (University Center Ballroom) 2000 Lakeshore Drive, New Orleans, LA 70148</td>
<td>9:00 AM or 2:00 PM</td>
</tr>
<tr>
<td>October 17</td>
<td>State Police Headquarters Auditorium 7919 Independence Blvd., Baton Rouge, LA 70806</td>
<td>9:00 AM or 2:00 PM</td>
</tr>
<tr>
<td>October 17</td>
<td>Heymann Center 1373 South College Rd., Lafayette, LA 70503</td>
<td>9:00 AM or 2:00 PM</td>
</tr>
<tr>
<td>October 24</td>
<td>Country Inn Conference Center 2727 Monroe Hwy., Pineville, LA 71360</td>
<td>9:00 AM or 2:00 PM</td>
</tr>
<tr>
<td>October 26</td>
<td>Southeastern Louisiana University (Student Union) 303 Texas Ave., Hammond, LA 70402</td>
<td>9:00 AM or 2:00 PM</td>
</tr>
<tr>
<td>October 30</td>
<td>Lake Charles Civic Center 900 Lakeshore Drive, Lake Charles, LA 70602</td>
<td>9:00 AM or 2:00 PM</td>
</tr>
<tr>
<td>November 6</td>
<td>Bossier City Civic Center 620 Benton Road, Bossier City, LA 71111</td>
<td>9:00 AM or 2:00 PM</td>
</tr>
</tbody>
</table>

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 more information regarding LSU First annual enrollment meetings.

* *meeting with an interpreter for hearing impaired members.*
Meeting Schedule
Retirees with Medicare

<table>
<thead>
<tr>
<th>DATE</th>
<th>LOCATION</th>
<th>START TIMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 3</td>
<td>West Monroe Civic Center 901 Ridge Ave., West Monroe, LA 71291</td>
<td>9:00 AM or 2:00 PM</td>
</tr>
<tr>
<td>October 10</td>
<td>Houma - Terrebonne Civic Center 346 Civic Center Blvd., Houma, LA 70360</td>
<td>9:00 AM or 2:00 PM</td>
</tr>
<tr>
<td>October 11</td>
<td>University of New Orleans (University Center Ballroom) 2000 Lakeshore Drive, New Orleans, LA 70148</td>
<td>9:00 AM or 2:00 PM</td>
</tr>
<tr>
<td>October 18</td>
<td>State Police Headquarters Auditorium 7919 Independence Blvd., Baton Rouge, LA 70806</td>
<td>9:00 AM* or 2:00 PM</td>
</tr>
<tr>
<td>October 18</td>
<td>Heymann Center 1373 South College Rd., Lafayette, LA 70503</td>
<td>9:00 AM or 2:00 PM</td>
</tr>
<tr>
<td>October 25</td>
<td>Country Inn Conference Center 2727 Monroe Hwy., Pineville, LA 71360</td>
<td>9:00 AM or 2:00 PM</td>
</tr>
<tr>
<td>October 31</td>
<td>Lake Charles Civic Center 900 Lakeshore Drive, Lake Charles, LA 70602</td>
<td>9:00 AM or 2:00 PM</td>
</tr>
<tr>
<td>November 2</td>
<td>Southeastern Louisiana University (Student Union) 303 Texas Ave., Hammond, LA 70402</td>
<td>9:00 AM or 2:00 PM</td>
</tr>
<tr>
<td>November 7</td>
<td>Bossier City Civic Center 620 Benton Road, Bossier City, LA 71111</td>
<td>9:00 AM or 2:00 PM</td>
</tr>
</tbody>
</table>

*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 more information regarding LSU First annual enrollment meetings.

*meeting with an interpreter for hearing impaired members.*
2019 Plan Options
OGB PLAN OPTIONS

OGB offers 5 self-insured plans through Blue Cross and Blue Shield of Louisiana:

• Pelican HRA1000
• Pelican HSA775
• Magnolia Local Plus
• Magnolia Open Access
• Magnolia Local

OGB also offers 1 fully-insured plan through Vantage Health Plan:

• Vantage Medical Home HMO
Pelican Plans

OGB’s Pelican plans offer coverage within Blue Cross and Blue Shield’s nationwide network, as well as Out-of-Network, to ensure members can receive care anywhere.
Pelican HRA1000

The Pelican HRA1000 includes $1,000 in annual employer contributions in a health reimbursement account for employee-only plans and $2,000 for employee plus dependent(s) plans in a health reimbursement account that can be used to offset deductible and other out-of-pocket health care costs throughout the year.

Any unused funds roll over each Plan year up to the In-Network out-of-pocket maximum, allowing members to build up balances that cover eligible medical expenses when they are incurred.
## Pelican HRA1000

### Medical Coverage

<table>
<thead>
<tr>
<th></th>
<th>Employee-Only</th>
<th>Employee + 1 (Spouse or Child)</th>
<th>Employee + Children</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer Contribution to HRA</td>
<td>$1,000</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Deductible (in-network)</td>
<td>$2,000</td>
<td>$4,000</td>
<td>$4,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Deductible (out-of-network)</td>
<td>$4,000</td>
<td>$8,000</td>
<td>$8,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>Out-of-pocket max (in-network)</td>
<td>$5,000</td>
<td>$10,000</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Out-of-pocket max (out-of-network)</td>
<td>$10,000</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>Coinsurance (in-network)</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Coinsurance (out-of-network)*</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
</tr>
</tbody>
</table>

*Once a member’s deductible for allowable is met, he or she will pay 40% of the allowable charge, plus 100% of the difference between the allowable charge and billed amount.

### Prescription Coverage

<table>
<thead>
<tr>
<th>Tier</th>
<th>Generic</th>
<th>Preferred</th>
<th>Non-Preferred</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Responsibility**</td>
<td>50% up to $30</td>
<td>50% up to $55</td>
<td>65% up to $80</td>
<td>50% up to $80</td>
</tr>
</tbody>
</table>

**Once you, or your covered dependent(s), pay $1,500 threshold:**

| Member Responsibility** | $0 co-pay     | $20 co-pay     | $40 co-pay     | $40 co-pay |

*Member responsibility is for a prescription drug benefit of up to a 31-day supply.*
Pelican HSA775

The Pelican HSA775 offers our lowest premiums in addition to a separate health savings account funded by both employers and employees. Employers contribute $200 to the HSA, then match any employee contributions up to $575. Employees can contribute to their HSA on a pre-tax basis, up to $3,500 for an individual and $7,000 for a family to cover out-of-pocket medical and pharmacy costs.

If you select the Pelican HSA775 plan, you must fill out a GB-79 form to open your Health Savings Account with a minimum deposit of $200 provided. Tax implications may apply for certain members.

This plan is available to Active Employees only.
## Medical Coverage

<table>
<thead>
<tr>
<th></th>
<th>Employee-Only</th>
<th>Employee + 1 (Spouse or child)</th>
<th>Employee + Children</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer Contribution to HSA</td>
<td>$200, plus up to $575 more dollar-for-dollar match of employee contributions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible (in-network)</td>
<td>$2,000</td>
<td>$4,000</td>
<td>$4,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Deductible (out-of-network)</td>
<td>$4,000</td>
<td>$8,000</td>
<td>$8,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>Out-of-pocket max (in-network)</td>
<td>$5,000</td>
<td>$10,000</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Out-of-pocket max (out-of-network)</td>
<td>$10,000</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>Coinsurance (in-network)</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Coinsurance (out-of-network)**</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
</tr>
</tbody>
</table>

**Once a member’s deductible for allowable charges is met, he or she will pay 40% of the allowable charge, plus 100% of the difference between the allowable charge and billed amount.

## Prescription Coverage

<table>
<thead>
<tr>
<th>Tier</th>
<th>Generic</th>
<th>Preferred</th>
<th>Non-Preferred</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Responsibility*</td>
<td>$10 co-pay</td>
<td>$25 co-pay</td>
<td>$50 co-pay</td>
<td>$50 co-pay</td>
</tr>
</tbody>
</table>

*Subject to deductible and applicable co-payment (except maintenance medications)
# HRA vs. HSA

<table>
<thead>
<tr>
<th>Health Reimbursement Arrangement (HRA)</th>
<th>Health Savings Account (HSA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Funding</strong></td>
<td></td>
</tr>
<tr>
<td>Employer funds HRA</td>
<td>Employer and employee fund HSA</td>
</tr>
<tr>
<td>Funds stay with the employer if an employee leaves an OGB-participating employer</td>
<td>Funds go with the employee when he/she leaves an OGB-participating employer</td>
</tr>
<tr>
<td>Contributions are not taxable</td>
<td>Contributions are made on a pre-tax basis</td>
</tr>
<tr>
<td>Only employers may contribute</td>
<td>Employers or employees may contribute</td>
</tr>
<tr>
<td><strong>Flexibility</strong></td>
<td></td>
</tr>
<tr>
<td>Employer selects maximum contribution</td>
<td>IRS determines maximum contribution</td>
</tr>
<tr>
<td>Must be paired with the Pelican HRA1000</td>
<td>Must be paired with the Pelican HSA 775</td>
</tr>
<tr>
<td>Contributions are the same for each employee</td>
<td>Contributions are determined by employee and employer</td>
</tr>
<tr>
<td>May be used with a General-Purpose FSA</td>
<td>May be used only with a Limited-Purpose FSA</td>
</tr>
<tr>
<td><strong>Simplicity</strong></td>
<td></td>
</tr>
<tr>
<td>HRA claims processed by the claims administrator</td>
<td>Employee manages account and submits expenses to the HSA trustee for reimbursement</td>
</tr>
<tr>
<td>IRS regulations and the Pelican HRA 1000 plan document govern expenses, funding and participation</td>
<td>IRS regulations govern expenses, funding and participation</td>
</tr>
<tr>
<td>Tax implications may apply</td>
<td></td>
</tr>
<tr>
<td><strong>Eligible expenses</strong></td>
<td></td>
</tr>
<tr>
<td>Can be used for medical expenses only</td>
<td>Can be used for pharmacy, dental, vision and medical expenses</td>
</tr>
</tbody>
</table>
Magnolia Local Plus
(Nationwide In-Network Providers)

The Magnolia Local Plus option offers the benefit of Blue Cross and Blue Shield’s nationwide In-Network providers. The Local Plus plan provides the predictability of copayments rather than using employer funding to offset out-of-pocket costs.

Out-of-Network care is covered only in emergencies, and the member may be balance billed.
Active Employees and non-Medicare retirees – retirement date ON or AFTER 3-1-2015

<table>
<thead>
<tr>
<th>Medical Coverage</th>
<th>Employee-Only</th>
<th>Employee + 1 (Spouse or child)</th>
<th>Employee + Children</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (in-network)</td>
<td>$400</td>
<td>$800</td>
<td>$1,200</td>
<td>$1,200</td>
</tr>
<tr>
<td>Deductible (out-of-network)</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
<tr>
<td>Out-of-pocket max (in-network)</td>
<td>$3,500</td>
<td>$6,000</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>Out-of-pocket max (out-of-network)</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
<tr>
<td>Co-Payment (in-network)</td>
<td>$25 / $50</td>
<td>$25 / $50</td>
<td>$25/$50</td>
<td>$25/$50</td>
</tr>
<tr>
<td>Co-Payment (out-of-network)</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
</tbody>
</table>

**Member responsibility is for a prescription drug benefit of up to a 31-day supply.**

<table>
<thead>
<tr>
<th>Prescription Coverage</th>
<th>Tier</th>
<th>Generic</th>
<th>Preferred</th>
<th>Non-Preferred</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Responsibility</strong></td>
<td>50% up to $30</td>
<td>50% up to $55</td>
<td>65% up to $80</td>
<td>50% up to $80</td>
<td></td>
</tr>
</tbody>
</table>

**Once you, or your covered dependent(s), pay $1,500 threshold:**

| **Member Responsibility** | $0 co-pay | $20 co-pay | $40 co-pay | $40 co-pay |

**Member responsibility is for a prescription drug benefit of up to a 31-day supply.**
## Magnolia Local Plus

### Non-Medicare retirees – retirement date BEFORE 3-1-2015

<table>
<thead>
<tr>
<th>Medical Coverage</th>
<th>Employee-Only</th>
<th>Employee + 1 (Spouse or child)</th>
<th>Employee + Children</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (in-network)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Deductible (out-of-network)</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
<tr>
<td>Out-of-pocket max (in-network)</td>
<td>$2,000</td>
<td>$3,000</td>
<td>$4,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Out-of-pocket max (out-of-network)</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
<tr>
<td>Co-Payment (in-network)</td>
<td>$25 / $50</td>
<td>$25 / $50</td>
<td>$25/$50</td>
<td>$25/$50</td>
</tr>
<tr>
<td>Co-Payment (out-of-network)</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
</tbody>
</table>

### Prescription Coverage

<table>
<thead>
<tr>
<th>Tier</th>
<th>Generic</th>
<th>Preferred</th>
<th>Non-Preferred</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Responsibility</strong></td>
<td>50% up to $30</td>
<td>50% up to $55</td>
<td>65% up to $80</td>
<td>50% up to $80</td>
</tr>
</tbody>
</table>

**Member responsibility is for a prescription drug benefit of up to a 31-day supply.**
Magnolia Open Access
(Nationwide Providers)

The Magnolia Open Access Plan offers coverage both inside and outside of Blue Cross and Blue Shield’s nationwide network. It differs from the other Magnolia plans in that members enrolled in the Open Access Plan will not pay copayments at physician visits. Instead, once a member’s deductible is met, he or she will pay 10% of the allowable amount for In-Network care and 30% of the allowable amount for Out-of-Network care. Out-of-Network care may be balance billed.

Though the premiums for the Magnolia Open Access plan are higher than OGB’s other plans, its moderate deductibles combined with a nationwide network make it an attractive plan for members who live out of state or travel regularly.
## Medical Coverage

<table>
<thead>
<tr>
<th></th>
<th>Employee-Only</th>
<th>Employee + 1 (Spouse or Child)</th>
<th>Employee + Children</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (in-network)</td>
<td>$900</td>
<td>$1,800</td>
<td>$2,700</td>
<td>$2,700</td>
</tr>
<tr>
<td>Deductible (out-of-network)</td>
<td>$900</td>
<td>$1,800</td>
<td>$2,700</td>
<td>$2,700</td>
</tr>
<tr>
<td>Out-of-pocket max (in-network)</td>
<td>$3,500</td>
<td>$6,000</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>Out-of-pocket max (out-of-network)</td>
<td>$4,700</td>
<td>$8,500</td>
<td>$12,250</td>
<td>$12,250</td>
</tr>
<tr>
<td>Coinsurance (in-network)</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Coinsurance (out-of-network)</td>
<td>30%</td>
<td>30%</td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>

## Prescription Coverage

<table>
<thead>
<tr>
<th>Tier</th>
<th>Generic</th>
<th>Preferred</th>
<th>Non-Preferred</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Responsibility</strong></td>
<td>50% up to $30</td>
<td>50% up to $55</td>
<td>65% up to $80</td>
<td>50% up to $80</td>
</tr>
</tbody>
</table>

**Once you, or your covered dependent(s), pay $1,500 threshold:**

| **Member Responsibility** | $0 co-pay | $20 co-pay | $40 co-pay | $40 co-pay |

**Member Responsibility is for a prescription drug benefit of up to a 31-day supply.**
## Magnolia Open Access

**Non-Medicare retirees – retirement date BEFORE 3-1-2015**

### Medical Coverage

<table>
<thead>
<tr>
<th></th>
<th>Employee-Only</th>
<th>Employee + 1 (Spouse or Child)</th>
<th>Employee + Children</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible (in &amp; out-of-network)</strong></td>
<td>$300</td>
<td>$600</td>
<td>$900</td>
<td>$900</td>
</tr>
<tr>
<td><strong>Out-of-pocket max (in-network)</strong></td>
<td>$2,300 individual; plus $1,300 per additional person up to 2; plus $1,000 per additional person up to 10 people; $13,700 for a family of 12+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-pocket max (out-of-network)</strong></td>
<td>$4,300 individual; plus $3,000 per additional person up to 2; $13,700 for a family of 4+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coinsurance (in-network)</strong></td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Coinsurance (out-of-network)</strong></td>
<td>30%</td>
<td>30%</td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>

### Prescription Coverage

<table>
<thead>
<tr>
<th>Tier</th>
<th>Generic</th>
<th>Preferred</th>
<th>Non-Preferred</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Responsibility</strong>**</td>
<td>50% up to $30</td>
<td>50% up to $55</td>
<td>65% up to $80</td>
<td>50% up to $80</td>
</tr>
</tbody>
</table>

**Once you, or your covered dependent(s), pay $1,500 threshold:**

<table>
<thead>
<tr>
<th>Tier</th>
<th>Generic</th>
<th>Preferred</th>
<th>Non-Preferred</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Responsibility</strong>**</td>
<td>$0 co-pay</td>
<td>$20 co-pay</td>
<td>$40 co-pay</td>
<td>$40 co-pay</td>
</tr>
</tbody>
</table>

*Member responsibility is for a prescription drug benefit of up to a 31-day supply.*
Magnolia Local
(Limited In-Network Provider Only Plan)

The Magnolia Local plan is a limited provider in-network 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 health care.

Out-of-network coverage is provided only in emergencies and members may be subject to balance billing.
Magnolia Local

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!

• Your residence will determine which Magnolia Local network you will use.

Before you choose Magnolia Local, consider this:

• Which doctors/clinics/hospitals do you go to the most?

• Are those providers in this network?

• 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

Magnolia Local has two networks:

**Community Blue**

Community Blue is a select, local network designed for members who live in the parishes of **Ascension, East Baton Rouge, Livingston, and West Baton Rouge**. You have access to the following hospitals in the Baton Rouge region:

- **Baton Rouge Region**
  - Baton Rouge General Hospital

**Blue Connect**

BlueConnect is a select, local network designed for members who live in the parishes of **Acadia, Bossier, Caddo, Evangeline, Iberia, Jefferson, Lafayette, Orleans, Plaquemines, St. Bernard, St. Charles, St. John the Baptist, St. Landry, St. Martin, St. Mary, St. Tammany, and Vermilion**. You have access to the following hospitals in the Greater New Orleans, Lafayette, Shreveport/Bossier, and St. Tammany regions:

- **Greater New Orleans Region**
  - Ochsner Health System

- **Lafayette Region**
  - Lafayette General Health System
  - Opelousas General
  - Abbeville General Hospital
  - Iberia Medical Center

- **St. Tammany Region**
  - Ochsner Medical Center Northshore
  - St. Tammany Parish Hospital

- **Shreveport Region**
  - CHRISTUS Schumpert of Shreveport
### Magnolia Local

**Active Employees and non-Medicare retirees – retirement date ON or AFTER 3-1-2015**

#### Medical Coverage

<table>
<thead>
<tr>
<th></th>
<th>Employee-Only</th>
<th>Employee + 1 (Spouse or child)</th>
<th>Employee + Children</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (in-network)</td>
<td>$400</td>
<td>$800</td>
<td>$1,200</td>
<td>$1,200</td>
</tr>
<tr>
<td>Deductible (out-of-network)</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
<tr>
<td>Out-of-pocket max (in-network)</td>
<td>$2,500</td>
<td>$5,000</td>
<td>$7,500</td>
<td>$7,500</td>
</tr>
<tr>
<td>Out-of-pocket max (out-of-network)</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
<tr>
<td>Co-Payment (in-network)</td>
<td>$25 / $50</td>
<td>$25 / $50</td>
<td>$25/$50</td>
<td>$25/$50</td>
</tr>
<tr>
<td>Co-Payment (out-of-network)</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
</tbody>
</table>

#### Prescription Coverage

<table>
<thead>
<tr>
<th>Tier</th>
<th>Generic</th>
<th>Preferred</th>
<th>Non-Preferred</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Responsibility**</td>
<td>50% up to $30</td>
<td>50% up to $55</td>
<td>65% up to $80</td>
<td>50% up to $80</td>
</tr>
</tbody>
</table>

**Once you, or your covered dependent(s), pay $1,500 threshold:**

| Member Responsibility** | $0 co-pay        | $20 co-pay        | $40 co-pay        | $40 co-pay      |

**Member responsibility is for a prescription drug benefit of up to a 31-day supply.**
## Non-Medicare retirees – retirement date BEFORE 3-1-2015

### Medical Coverage

<table>
<thead>
<tr>
<th></th>
<th>Employee-Only</th>
<th>Employee + 1 (Spouse or child)</th>
<th>Employee + Children</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible (in-network)</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Deductible (out-of-network)</strong></td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
<tr>
<td><strong>Out-of-pocket max (in-network)</strong></td>
<td>$1,000</td>
<td>$2,000</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td><strong>Out-of-pocket max (out-of-network)</strong></td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
<tr>
<td><strong>Co-Payment (in-network)</strong></td>
<td>$25 / $50</td>
<td>$25 / $50</td>
<td>$25/$50</td>
<td>$25/$50</td>
</tr>
<tr>
<td><strong>Co-Payment (out-of-network)</strong></td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
</tbody>
</table>

### Prescription Coverage

<table>
<thead>
<tr>
<th>Tier</th>
<th>Generic</th>
<th>Preferred</th>
<th>Non-Preferred</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Responsibility</strong></td>
<td>50% up to $30</td>
<td>50% up to $55</td>
<td>65% up to $80</td>
<td>50% up to $80</td>
</tr>
</tbody>
</table>

**Once you, or your covered dependent(s), pay $1,500 threshold:**

| **Member Responsibility** | $0 co-pay | $20 co-pay | $40 co-pay | $40 co-pay |

**Member responsibility is for a prescription drug benefit of up to a 31-day supply.**
### Examples of Additional Plan Co-payments

<table>
<thead>
<tr>
<th>Service (In-Network)</th>
<th>Co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance – Ground</td>
<td>$50</td>
</tr>
<tr>
<td>Ambulatory/Outpatient Surgical Center (Facility Charge)</td>
<td>$100</td>
</tr>
<tr>
<td>Emergency Room (Facility Charge)</td>
<td>$200 co-payment per visit; waived if admitted</td>
</tr>
<tr>
<td>High Tech Imaging – Outpatient (Facility Charge)</td>
<td>$50</td>
</tr>
<tr>
<td>Inpatient Hospital Admission</td>
<td>$100 co-payment per day; max $300 per admission</td>
</tr>
<tr>
<td>Mental Health - Inpatient (Facility Charge)</td>
<td>$100 co-payment per day; max $300 per admission</td>
</tr>
<tr>
<td>Pregnancy Care –Physician Services</td>
<td>$90 co-payment per pregnancy</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>$100 co-payment per day; max $300 per admission</td>
</tr>
</tbody>
</table>

Eligible expenses are reimbursed in accordance with a fee schedule of maximum allowable charges, not billed charges.
Examples of Services Subject to the Plan Year Deductible

<table>
<thead>
<tr>
<th>Service (In-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient/Outpatient Professional Services</td>
</tr>
<tr>
<td>Chemotherapy/Radiation Therapy – Outpatient Facility</td>
</tr>
<tr>
<td>X-ray and Laboratory Services (low tech imaging) – Hospital Facility</td>
</tr>
<tr>
<td>Emergency Medical Services</td>
</tr>
<tr>
<td>Dialysis</td>
</tr>
<tr>
<td>Home Health Care</td>
</tr>
<tr>
<td>Hospice Care</td>
</tr>
<tr>
<td>Oral Surgery – Not performed in a Physicians Office</td>
</tr>
</tbody>
</table>

Eligible expenses are reimbursed in accordance with a fee schedule of maximum allowable charges, not billed charges.
Vantage Medical Home HMO

Vantage Medical Home HMO is a patient-centered approach to providing cost-effective and comprehensive primary health care for children, youth and adults. This plan creates partnerships between the individual patient and his or her personal physician. This plan includes a preferred provider network, Affinity Health Network (AHN), which has lower co-payments for certain covered services as indicated by “AHN.”

This plan also includes Out-of-Network coverage.
**Vantage Medical Home HMO**

**Active employees and Retirees without Medicare – retirement date AFTER 3-1-2015**

### Medical Coverage

<table>
<thead>
<tr>
<th></th>
<th>Employee-Only</th>
<th>Employee +1 (Spouse or child)</th>
<th>Employee + Children</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (In-Network)</td>
<td>$400</td>
<td>$800</td>
<td>$1,200</td>
<td>$1,200</td>
</tr>
<tr>
<td>Deductible (Out-of-Network)</td>
<td>$1,500</td>
<td>$3,000</td>
<td>$4,500</td>
<td>$4,500</td>
</tr>
<tr>
<td>Out-of-pocket max (In-Network)</td>
<td>$3,500</td>
<td>$6,000</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>Out-of-pocket max (Out-of-Network)</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Co-Payment PCP (In-Network)</td>
<td>$10 AHN/$20</td>
<td>$10 AHN/$20</td>
<td>$10 AHN/$20</td>
<td>$10 AHN/$20</td>
</tr>
<tr>
<td>Co-Payment Specialist (In-Network)</td>
<td>$35 AHN/$45</td>
<td>$35 AHN/$45</td>
<td>$35 AHN/$45</td>
<td>$35 AHN/$45</td>
</tr>
<tr>
<td>Coinsurance – PCP (Out-of-Network)</td>
<td>50% coverage; subject to out-of-network deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coinsurance – SPC (Out-of-Network)</td>
<td>50% coverage; subject to out-of-network deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Prescription Coverage

<table>
<thead>
<tr>
<th>Tier</th>
<th>Member Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 Preferred Generics</td>
<td>$5</td>
</tr>
<tr>
<td>Tier 2 Non-Preferred Generics</td>
<td>$20</td>
</tr>
<tr>
<td>Tier 3 Preferred Brand</td>
<td>$50</td>
</tr>
<tr>
<td>Tier 4 Non-Preferred Brand</td>
<td>$80</td>
</tr>
<tr>
<td>Tier 5 Specialty</td>
<td>$150</td>
</tr>
</tbody>
</table>

**In-Network Providers**

Members seeing In-Network providers pay the In-Network co-pays, co-insurance and deductibles as listed in the Certificate of Coverage and Cost Share Schedule. Vantage’s network consists of two participating provider networks:
- A preferred provider network, Affinity Health Network (AHN), which has lower co-payments for certain covered services; and
- A standard provider network
## Vantage Medical Home HMO

### Medical Coverage

<table>
<thead>
<tr>
<th></th>
<th>Employee-Only</th>
<th>Employee +1 (Spouse or child)</th>
<th>Employee + Children</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (In-Network)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Deductible (Out-of-Network)</td>
<td>$1,500</td>
<td>$3,000</td>
<td>$4,500</td>
<td>$4,500</td>
</tr>
<tr>
<td>Out-of-pocket max (In-Network)</td>
<td>$2,000</td>
<td>$3,000</td>
<td>$4,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Out-of-pocket max (Out-of-Network)</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Co-Payment PCP (In-Network)</td>
<td>$10 AHN/$20</td>
<td>$10 AHN/$20</td>
<td>$10 AHN/$20</td>
<td>$10 AHN/$20</td>
</tr>
<tr>
<td>Co-Payment Specialist (In-Network)</td>
<td>$35 AHN/$45</td>
<td>$35 AHN/$45</td>
<td>$35 AHN/$45</td>
<td>$35 AHN/$45</td>
</tr>
<tr>
<td>Coinsurance – PCP (Out-of-Network)</td>
<td></td>
<td>50% coverage; subject to out-of-network deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coinsurance – SPC (Out-of-Network)</td>
<td></td>
<td>50% coverage; subject to out-of-network deductible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Prescription Coverage

<table>
<thead>
<tr>
<th>Tier</th>
<th>Member Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 Preferred Generics</td>
<td>$5</td>
</tr>
<tr>
<td>Tier 2 Non-Preferred Generics</td>
<td>$20</td>
</tr>
<tr>
<td>Tier 3 Preferred Brand</td>
<td>$50</td>
</tr>
<tr>
<td>Tier 4 Non-Preferred Brand</td>
<td>$80</td>
</tr>
<tr>
<td>Tier 5 Specialty</td>
<td>$150</td>
</tr>
</tbody>
</table>

### In-Network Providers

Members seeing In-Network providers pay the In-Network co-pays, co-insurance and deductibles as listed in the Certificate of Coverage and Cost Share Schedule. Vantage’s network consists of two participating provider networks:

- A preferred provider network, Affinity Health Network (AHN), which has lower co-payments for certain covered services; and
- A standard provider network
Requests for proposals (RFPs) for the Medicare Advantage plans offered by OGB are currently being reviewed by the Office of State Procurement (OSP). OGB anticipates these proposals will be reviewed and contracts will be awarded in time for the annual enrollment period. OGB will send out information to our Medicare eligible retirees in the mail. Information will also be posted on OGB’s websites info.groupbenefits.org and www.annualenrollment.groupbenefits.org.

OGB encourages Medicare retirees to attend one of the Annual Enrollment informational meetings being held state wide. More information regarding the Medicare Advantage plans will be available at these meetings. In addition, OGB staff and vendors will be on hand to answer any questions members may have about their OGB Medicare coverage.

Medicare retirees can also select from five OGB plans during annual enrollment: the Pelican HRA1000 and the Magnolia plans, administered by Blue Cross and Blue Shield of Louisiana, and the Vantage Medical Home HMO plan. These plans will be secondary to Medicare.
We encourage you to make sure you choose a doctor or hospital in your provider network when you need healthcare. By choosing network providers, you avoid the possibility of having your provider bill you for amounts in addition to applicable co-payments, coinsurance, deductibles and non-covered services. (Often referred to as balance billing.)
Eligibility
The following people can be enrolled as dependents:

- Your legal Spouse
- Children until they reach the applicable attainment age

**Children are defined as:**

<table>
<thead>
<tr>
<th>Dependent Child</th>
<th>Attainment Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural child of employee or legal spouse (i.e.- stepchild)</td>
<td>26</td>
</tr>
<tr>
<td>Legally adopted child of employee</td>
<td>26</td>
</tr>
<tr>
<td>Child placed for adoption with employee</td>
<td>26</td>
</tr>
<tr>
<td>Unmarried child for whom the (primary) Plan member has court-ordered legal custody or court-ordered legal guardianship</td>
<td>18</td>
</tr>
<tr>
<td>Unmarried grandchild who resides with the (primary) Plan member and for whom the member has legal custody</td>
<td>26</td>
</tr>
</tbody>
</table>
Dependents

To add a newborn as a dependent, the member must provide human resources with a birth certificate or a copy of the birth letter, along with a completed GB-01, within 30 days of the child’s birth date.

The birth letter will suffice as proof of parentage only if it contains the relationship of the child and the employee.

If the birth certificate or birth letter is not received within 30 days, enrollment cannot take place until the next annual enrollment period or the member experiences a Plan-Recognized Qualified Life Event (QLE) that allows for addition of the child*. HR staff should follow up with member for copy of infant’s social security card within 6 months.

*Subject to Plan exceptions
Dependent Verification

Members must provide human resources with proof of the legal relationship and eligibility of each newly eligible dependent. Without that documentation, enrollment cannot be completed.

Examples of acceptable documents for certain QLEs include:

- Marriage Certificate
- Birth letter or birth certificate
- Legal adoption or placement for adoption papers, court-ordered custody papers or court-ordered legal guardianship papers, if applicable

Human Resources must verify and certify the eligibility of newly eligible dependents by executing the GB-01.
Dependent Verification

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

- **Stepchild(ren)**
  - Provide the following dependent Verification documents to OGB within 30 days of eligibility:
    - Provide OGB with a copy of marriage certificate
    - Provide OGB with a copy of stepchild(ren)’s birth certificate

- **Legal Custody/Guardianship Dependent**
  - Legal custody must be granted before child turns 18 years of age
  - Child may remain covered until age 18
  - Provide the following dependent Verification documents to OGB within 30 days of eligibility:
    - Copy of legal custody decree
    - Copy of child(ren)’s birth certificate

Human Resources must verify and certify the eligibility of newly eligible dependents by executing the GB-01.
Dependent Verification

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

- **Grandchildren**
  - Legal custody must be granted before grandchild turns 18 years of age
  - Unmarried grandchild may remain covered until age 26
  - Provide the following dependent Verification documents to OGB within 30 days of eligibility:
    - Copy of legal custody decree
    - Copy of child(ren)’s birth certificate
    - Copy of child(ren)’s social security card

Human Resources must verify and certify the eligibility of newly eligible dependents by executing the GB-01.
Plan-Recognized Qualified Life Events

The Office of Group Benefits (OGB) provides a chart advising agencies of *OGB Plan-Recognized Qualified Life Events* that allow for plan changes outside of annual enrollment.

- Agencies may access the QLE chart through the OGB secure website under Frequently Accessed Materials.
- Members may access the QLE chart through the main OGB website under Resources.

Agencies are responsible for disseminating the QLEs to their employees.
Agency Checklist

For Employees Who Are Retiring

- Verify applicable participation rate with OGB
- Verify life insurance amount – check accuracy of salary shown in e-Enrollment (if applicable)
- Verify and obtain certification of actual retirement date with retirement system
- Agency and member are required to pay the active premium until eligible for the retiree coverage rate. (See next slide)
- Verify that retiree will receive an “immediate retirement plan distribution” or otherwise meets requirements of LAC 32:1.305
- Verify life insurance beneficiary (if applicable)
- COLLECT 1 TO 3 MONTHS OF HEALTH AND/OR LIFE INSURANCE PREMIUMS
- Verify employee’s contact information, including mailing address, email address and phone number
Retirement Coverage Effective Date

• Retiree coverage will be effective on the first day of the month following the day of retirement, if the Retiree and the Participant Employer have agreed to make and are making the required contributions.

• For purposes of eligibility, the date of retirement shall be the date the person is eligible to receive a retirement plan distribution. (*This date is determined by the retirements systems*)
  • For example:
    • Retirement date is 7/15, retiree coverage will begin 8/1
    • Retirement date is 8/1, retiree coverage will begin 9/1.
Sample Retiree Documents

Office of Human Resources
State of Louisiana
Division of Administration

DATE: ____________________________
TO: ____________________________
FROM: ____________________________
HEALTH PLAN ____________________ COVERAGE ____________________________
PREMIUM AMOUNT ___________ LIFE PREMIUM ___________ TOTAL ___________

You are responsible for paying your health and life premiums to the Division of Administration until the deduction is taken from your retirement check. The insurance deduction from your retirement check usually takes 3 to 4 months to complete. During that time you are to mail a check made out to the Division of Administration in the amount listed above until the premium has been successfully deducted from your retirement check.

Please mail all correspondence to the following address:

Division of Administration
P.O. Box 94095
Baton Rouge, LA 70804

The health premium rate will not change until you are eligible for Medicare. At this time you are to mail a copy of your Medicare card(s) to the Office of Group Benefits, P.O. Box 44036, Baton Rouge, LA 70804. Only when Group Benefits receives this information will they lower your monthly premium.

As a retiree, the Office of Group Benefits will notify you directly of any changes in health coverage, including new providers and premiums that are available.

If you currently have insurance through a miscellaneous vendor and you wish to continue your coverage through retirement you will need to follow these steps. 1) You will need to contact LASERS to verify if the coverage is eligible for deduction from your retirement check, if not 2) you will need to make arrangements with the vendor to set up a direct payment plan.

If you have any questions concerning this matter, please call me at (225) 342-6060.

Sincerely,

Division of Administration
P.O. Box 94095
Baton Rouge, Louisiana 70804-9095
(225) 342-6060 • 1-800-354-9548 • Fax (225) 219-9558
An Equal Opportunity Employer

March 29, 2018

[Redacted]

Re: Health Insurance Premiums

Dear Ms. [Redacted]:

In February 2018, you retired from the Division of Administration-Office of Technology Services. Unfortunately, we have not received a payment for your health and life insurance premiums for the following month(s). Please remit payment as soon as possible to avoid any lapse in insurance coverage.

<table>
<thead>
<tr>
<th>Premium Month</th>
<th>Billed</th>
<th>Paid</th>
<th>Balance Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2018</td>
<td>$548.54</td>
<td>$0</td>
<td>$548.54</td>
</tr>
</tbody>
</table>

Please make your check payable to the Division of Administration and mail it to:

Attn: April White Ray
Division of Administration
Office of Human Resources
P.O. Box 94095
Baton Rouge, LA 70804-9095

Please feel free to contact me with any questions or concerns regarding this matter.

Kind Regards,

April Ray
Human Resource Analyst
Tel: 225.342.9550 | cr: 225.219.9558 | ew: April.Ray@la.gov

P.O. Box 94095 • Baton Rouge, Louisiana 70804-9095 • (225) 342-6060 • 1-800-354-9548 • Fax (225) 219-9558
An Equal Opportunity Employer
June 5, 2016

[Name Redacted]

Re: Health and Life Insurance Premiums

Dear [Name Redacted],

In October 2017, you became a retiree of the Office of Technology Services. We received a partial payment for your insurance premiums, since the amount due was incorrectly calculated based on the 38% participation health insurance premiums rates for plan year 2017. Please remit payment as soon as possible to avoid any lapse.

<table>
<thead>
<tr>
<th>Premium Month</th>
<th>Original Billing</th>
<th>Paid</th>
<th>Corrected Billing</th>
<th>Balance Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2017</td>
<td>$494.58</td>
<td>$494.58</td>
<td>$626.65</td>
<td>$132.07</td>
</tr>
<tr>
<td>December 2017</td>
<td>$494.58</td>
<td>$494.58</td>
<td>$576.65</td>
<td>$195.07</td>
</tr>
<tr>
<td>Total</td>
<td>$989.16</td>
<td>$989.16</td>
<td>$1203.30</td>
<td>$264.14</td>
</tr>
</tbody>
</table>

Please make your check payable to the Division of Administration and mail it to:

Attn:
Division of Administration
Office of Human Resources
P.O. Box 94035
Baton Rouge, LA 70804-9035

Please feel free to contact me with any questions or concerns regarding this matter.

Kind Regards,

[Name Redacted]

Human Resource Analyst
Tel: 225.342.6060 | FAX: 225.219.9558 | Email: April.Tay@la.gov
Future Retirees

- Applicable OGB coverage must be in effect immediately prior to a member’s retirement to be eligible for retiree coverage. If the member started participation or rejoined state service on or after January 1, 2002, the state contribution of their premium is based on the number of participation years in an OGB health plan. This also applies to a surviving spouse/dependent who started coverage after July 1, 2002.

- The participation schedule below shows the number of years a member must participate in an OGB health plan to receive a specified state contribution.

<table>
<thead>
<tr>
<th>Years of OGB Plan Participation</th>
<th>State’s Share of Total Monthly Health Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 years or more</td>
<td>75 percent</td>
</tr>
<tr>
<td>15 years but less than 20 years</td>
<td>56 percent</td>
</tr>
<tr>
<td>10 years but less than 15 years</td>
<td>38 percent</td>
</tr>
<tr>
<td>less than 10 years</td>
<td>19 percent</td>
</tr>
</tbody>
</table>

*Includes LSU First
Retirement Requirements

• Within 30 days of retirement, a GB-01 MUST be submitted indicating whether or not the member wishes to maintain OGB insurance into retirement.

• If no GB-01 is received, coverage will be terminated at the end of the month of retirement.

• See QLE Chart L-1, L-2 or L-3
Rehired Retirees

If an agency hires a retiree who did not carry coverage into retirement, the rehired retiree may enroll in a health plan with the following provisions:

• The retiree is hired as a full-time employee or FTE under the ACA or in a benefit-eligible position (could be <13/26 weeks, etc.)

• The employee’s and agency’s premium contribution will be based upon the retiree’s participation level at retirement

• The employee’s rate will be RN (retired, no Medicare) – CMS rules state that OGB will be primary over Medicare while the retiree is rehired

• The employee’s coverage will be terminated once he or she separates from the agency.
Rehired Retirees

If an agency hires a retiree full-time who **has** health coverage through OGB*:

- Transfer coverage to active status
- The employee’s and agency’s premium contribution will be based upon the retiree’s participation level at retirement
- Submit GB-01 to let OGB know to move the rehired retiree to 92 invoice within 30 days of rehire
- Receiving agency must deduct from the rehired retiree’s active check and **pay the agency contribution**
- Notify OGB with GB-01 within 30 days of a rehired retiree going back into retirement

* This rule applies to retirees who were rehired on or after 1/1/2018.
HSA Account & Deductions
Health Savings Account Enrollment

Non-LaGov:

• Enrollment must be done in eEnrollment
• **DO NOT** send paper application to HealthEquity
• **NOTE:** Once HealthEquity opens the account, the employee’s name will appear in the “HSA Opened Accounts” folder under the “Miscellaneous Documents” link. Monthly deductions can only be entered after HealthEquity opens the account.
• Current HSA participants must re-enroll every year by completing a GB-79 or enrolling through the online portal
• Monthly deductions must be entered in eEnrollment; member can change this monthly if desired
• Agency and plan member contribution will only be sent to HealthEquity after the account has been opened
Health Savings Account Enrollment

LaGov

- LaGov enrollment must be done in the LEO application or in the HCM Benefits Module
- **DO NOT** send paper application to HealthEquity
- **NOTE:** Once HealthEquity opens the account, the employee’s name will appear in the “HSA Opened Accounts” folder under the “Miscellaneous Documents” link. **Monthly deductions can only be entered after HealthEquity opens the account.**
- Current HSA participants must re-enroll every year by completing a GB-79 or enrolling through the online portal
- Monthly deductions must be entered in the HCM benefits module; participants can change this monthly if desired
- Agency and plan member contributions will only be sent to HealthEquity after the account has been opened
Invoicing – Billing Information

- Each month OFSS generates an invoice for each participating agency.
- Invoice is available to the agency on the OGB secure website.

Based upon current enrollment data

Invoice ready for reconciliation by the 1st of each month

Agency submits payment with reconciliation worksheet(s) by the last day of the month
IMPORTANT!

Please be aware that the amount on the invoice is what is due to OGB. **You must reconcile to the OGB invoice monthly and not just your payroll system.** If there are discrepancies or if what is in your payroll system does not match what OGB has billed on the invoice, you must contact OGB HR Helpdesk to have those discrepancies resolved.
Invoicing – HSA Billing Information

IMPORTANT!

HSA funds will **NOT** be transferred to the member’s HealthEquity account until the agency has remitted the funds to the Office of Finance and Support Services (OFSS) and those funds have been verified by OFSS staff.
Invoicing – Training Information

OFSS offers one-on-one training for agency personnel on that covers:

• OGB Invoice Reconciliation Process
• HSA
• EMR (ENROLLEE MONITORING REPORT)

Contact your OFSS representative to schedule
ENROLLEE MONITORING REPORT (EMR) PROCESS
Monthly EMR Report

Primary communication tool to show issues that need to be addressed between agency, OGB and OFSS.

- Shows possible amounts due to OGB or credits due to agency or members.
- Shows discrepancies that may exist between the agency and OGB’s records.
- Documentation may need to be provided to OGB or corrected in OGB’s system.
How the Reconciliation Process SHOULD Work

1. **OGB enters enrollment or change into system**
2. **OFSS reconciles the agency payment and supporting documentation against OGB enrollment data**
3. **OFSS sends EMR* report to agency when there is a discrepancy**
4. **Agency reconciles the EMR* with their records and makes any corrections that need to be made**
5. **Appropriate corrections, payments and credits will be reflected on your next EMR**

*Documents NOT submitted TIMELY AND ACCURATELY by agencies is a factor of why there are so many lines on the EMR.*
OFSS produces an Enrollee Monitoring Report (EMR) each month.

- The Commissioner of Administration is actively monitoring the progress on your agency’s EMR.
- Serious consequences may occur when discrepancies remain unresolved.
- Letters are being mailed out to members who have balances owed to OGB. These balances due are reflected on your agency’s EMR.
- Accounts are being sent to the Office of Debt Recovery if payment is not received, and in some cases, coverage is being terminated.
- In order to resolve discrepancies on your agency’s EMR, the below actions should be taken:
  - Contact the appropriate Helpdesk
  - Make payments or take credits for the amounts due, and contact OFSS or OGB to discuss any issues for which the agency does not agree
  - Visit the OGB secure website for a listing of agency accountants.
    (Agency>Misc. Documents>Invoice>OFSS Agency Representatives and Contact Numbers)
## Enrollee Monitoring Report

**Agency Name**

**Month:** 8/18

<table>
<thead>
<tr>
<th>SS#</th>
<th>Name</th>
<th>LOC</th>
<th>Invoice Month</th>
<th>Over/Under Month</th>
<th>Health/Life</th>
<th>Member Share</th>
<th>State Share</th>
<th>Total</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>55555555555</td>
<td>Doe, Bob</td>
<td>00</td>
<td>2/1/2018</td>
<td>2/1/2018</td>
<td>Health</td>
<td>310.92</td>
<td>0.00</td>
<td>310.92</td>
<td>FM TO CC COVERAGE EFF 2/1/18; OVERPAYMENT OF PREMIUMS</td>
</tr>
<tr>
<td>987654321</td>
<td>Doe, John</td>
<td>95</td>
<td>2/1/2018</td>
<td>1/1/2018</td>
<td>Health</td>
<td>0.00</td>
<td>506.78</td>
<td>506.78</td>
<td>PM DECEASED; NO PAYMENT DUE</td>
</tr>
<tr>
<td>2221110000</td>
<td>Geaux, Tigers</td>
<td>99</td>
<td>2/1/2018</td>
<td>2/1/2018</td>
<td>Life</td>
<td>587.74</td>
<td>925.68</td>
<td>1,513.42</td>
<td>TRANSFERRED OUT EFF 2/1/18; NO PAYMENT DUE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SS#</th>
<th>Name</th>
<th>LOC</th>
<th>Invoice Month</th>
<th>Over/Under Month</th>
<th>Health/Life</th>
<th>Member Share</th>
<th>State Share</th>
<th>Total</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456789</td>
<td>Doe, Mary</td>
<td>00</td>
<td>12/1/2017</td>
<td>11/1/2017</td>
<td>Health</td>
<td>168.88</td>
<td>506.78</td>
<td>675.66</td>
<td>COV EFF 11/1/17; NO PAYMENT RECEIVED</td>
</tr>
<tr>
<td>123456789</td>
<td>Doe, Mary</td>
<td>00</td>
<td>12/1/2017</td>
<td>12/1/2017</td>
<td>Health</td>
<td>168.88</td>
<td>506.78</td>
<td>675.66</td>
<td>COV EFF 11/1/17; NO PAYMENT RECEIVED</td>
</tr>
<tr>
<td>444555666</td>
<td>First, Last</td>
<td>99</td>
<td>2/1/2017</td>
<td>2/1/2017</td>
<td>Health</td>
<td>78.89</td>
<td>230.89</td>
<td>309.78</td>
<td>ES2M TO BE 1M EFF 2/1/17; OVERPAYMENT OF PREMIUMS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SS#</th>
<th>Name</th>
<th>LOC</th>
<th>Invoice Month</th>
<th>Over/Under Month</th>
<th>Health/Life</th>
<th>Member Share</th>
<th>State Share</th>
<th>Total</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>5554443333</td>
<td>Last, First</td>
<td>00</td>
<td>5/1/2016</td>
<td>5/1/2016</td>
<td>Life</td>
<td>243.06</td>
<td>(580.95)</td>
<td>(824.00)</td>
<td>NO PAYMENT RECEIVED; NEED UP TO DCS</td>
</tr>
<tr>
<td>543212345</td>
<td>Name, Name</td>
<td>00</td>
<td>8/1/2016</td>
<td>8/1/2016</td>
<td>Life</td>
<td>(5.00)</td>
<td>(5.00)</td>
<td>(10.00)</td>
<td>NO PAYMENT RECEIVED</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SS#</th>
<th>Name</th>
<th>LOC</th>
<th>Invoice Month</th>
<th>Over/Under Month</th>
<th>Health/Life</th>
<th>Member Share</th>
<th>State Share</th>
<th>Total</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>999888777</td>
<td>Spouse1, Spouse2</td>
<td>97</td>
<td>7/1/2015</td>
<td>7/1/2015</td>
<td>Life</td>
<td>0.00</td>
<td>5.00</td>
<td>3.92</td>
<td>OVERPAYMENT; NO LIFE</td>
</tr>
<tr>
<td>8865554444</td>
<td>Thing1, Thing2</td>
<td>00</td>
<td>9/1/2015</td>
<td>9/1/2015</td>
<td>Life</td>
<td>(2.08)</td>
<td>0.00</td>
<td>(2.08)</td>
<td>DID NOT PAY FOR DEP LIFE</td>
</tr>
</tbody>
</table>

**Total Lines:** 10  
**Affected Members:** 9

**Assigned OFSS Accountant**

**Assigned OFSS Accountant@La.Gov**

225.342.7000
Other Benefit Offerings
The following OGB Plan-Recognized Qualified Life Events require the completion of a GB-01:

- Qualifying events for a covered employee:
  - Termination of the covered employee's employment for any reason other than "gross misconduct"; or
  - Reduction in the covered employee's hours of employment.

- Qualifying events for a spouse and dependent child of a covered employee:
  - Termination of the covered employee's employment for any reason other than "gross misconduct";
  - Reduction in hours worked by the covered employee;
  - Covered employee becomes entitled to Medicare;
  - Divorce, legal separation or annulment (in states where recognized) of marriage of the spouse from the covered employee;
  - Death of the covered employee; or
  - Loss of "dependent child" status under the Plan rules.
COBRA

Members that experience a qualifying event and become eligible for and elect COBRA will be invoiced by Discovery Benefits, Inc. (DBI). Members will remit payment directly to DBI, either by mail, by ACH drafts from their bank accounts, or by credit card online, or online through Discovery Benefits’ Participant COBRA web portal (online payments are subject to a $20 processing fee).

- Payment processing center address:
  Discovery Benefits Inc.
  PO Box 2079
  Omaha, NE 68103-2079

- COBRA participant services
  866-451-3399 – click option 1, click option 2 when prompted
  888-408-7224 (fax)
  cobraadmin@discoverybenefits.com

- Participant COBRA web portal:
  https://cobra.discoverybenefits.com
FSA COBRA

FSA COBRA is offered, along with COBRA, to termed participants:

• who participate in GPFSA and LPFSA only;
• if termed participants have money left in their account; and
• as long as they pay their contribution plus the administrative fee directly to Discovery Benefits, Inc. (DBI), until the plan year ends (12/31/(year)).

If termed participants do not accept FSA COBRA, their claims must be filed no later than the end of the Run-Out Period for the Plan Year in which the expense(s) incurred during the plan year’s participation. The Run-Out Period ends April 30, of the following year.

For example:

• Joe’s FSA started 02/15/2018. Joe termed 06/15/2018.
• Joe can request reimbursement from DBI for claims incurred between the start of his FSA, which was 02/15/2018, and his term date of 06/15/2018.
• He has until April 30, 2019, to request reimbursement.

If you have questions, please address them to cobra@la.gov.
Life Insurance
Life Insurance

- OGB offers two fully-insured life insurance plans (Basic and Basic Plus Supplemental) for employees and retirees.
- The one year emergency contract with Prudential expires on 12/31/18.
- A request for proposals (RFP) was posted on 5/16/2018
- OGB received 5 proposals
- The contract award was protested
- Life Insurance vendor and rates are to be determined
- The payout amounts will remain the same as shown in the following chart.
Flexible Benefits
What are Flexible Benefits?

- Flexible Benefits are tax-saving benefits allowing employees to save both state and federal income taxes on eligible payroll deductions for health care and dependent care.
Flexible Spending Arrangement Options

There are four Flexible Spending Arrangement options available to eligible OGB members:

• Premium Conversion
• General-Purpose FSA (GP FSA)
• Limited-Purpose FSA (LP FSA)
• Dependent Care FSA (DCFSA)
Flexible Benefits – Enrollment Opportunities

- New Hires, newly-eligible employees under ACA, & Rehired Retirees (Full-Time/ACA Full-Time)
  30 day window for:
  - General-Purpose or Limited-Purpose FSA
  - Dependent Care FSA
- Employees who experience certain OGB Plan-Recognized Qualified Life Events
- Plan members have a 30-day window to submit their paperwork to Human Resources after the OGB Plan-Recognized Qualified Life Event happens
- Annual Enrollment:
  - October 1 – November 15
Automatic Annual Enrollment

• Employees of agencies that participate in the OGB administered Flexible Benefits Plan will automatically be enrolled in the Premium Conversion option for all OGB products and eligible miscellaneous products.

• Once enrolled in the Premium Conversion option, enrollment will automatically continue from year to year unless the employee chooses to end participation in all coverage during annual enrollment or due to experiencing an OGB Plan-Recognized Qualified Life Event. See the Flex Plan document for additional information.
Flexible Spending Arrangement

Participation

Money deducted from an employee’s pay and placed into a FSA is not subject to payroll taxes, resulting in substantial tax savings.

Available FSAs:

- General-Purpose Health Care FSA (not available to Pelican HSA775)
- Limited-Purpose Dental/Vision FSA
- Dependent Care FSA

Employees can participate in a Flexible Spending Arrangement even if they are not enrolled in an OGB health plan.
Flexible Spending Arrangement

Enrollment Process:

• Non-LaGov employees currently enrolled in health coverage can enroll/re-enroll in FSAs online through the OGB Annual Enrollment Portal.

• LaGov active employees can enroll/re-enroll in FSAs online through LEO Enrollment Application.

• Non-LaGov and LaGov employees may enroll through their Human Resources Department.
FSA Eligibility and Enrollment

General-Purpose FSA, Limited-Purpose FSA and Dependent Care FSA:

- Must be an active, full-time employee or FTE in a participating payroll system
- Can enroll during Annual Enrollment or after experiencing certain OGB Plan-Recognized Qualified Life Events
- Must **re-enroll** each year to continue participation and agree to pay the annual administrative fee (currently $34.80)
- New hires must enroll within their first thirty (30) days of full-time employment; participation will be effective the first of the following month after the first full calendar month of employment.
  - For example: if Date of Hire is August 20\(^{th}\), Effective Date is October 1\(^{st}\).

General-Purpose FSA & Limited-Purpose FSA Amounts
2019 Maximum and Minimum amounts have not been determined.
Dependent Care FSA

- For eligible dependent care expenses while you work
- Submission of dependent care expenses can be reduced by signing up for DCFSA recurring Expense Service
- Reimbursement is limited to current amount in account
- Minimum annual amount is $600, the maximum amount is dependent on the employee’s tax-filing status (see next slide)
- Must **re-enroll** each year to continue participation
- Must file IRS Form 2441
## Dependent Care FSA

### PLAN YEAR MAXIMUM AMOUNTS

<table>
<thead>
<tr>
<th>EMPLOYEE TAX STATUS</th>
<th>MAXIMUM AMOUNT</th>
<th>ALLOWED DEPENDENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>SINGLE OR MARRIED FILING SEPARATELY</td>
<td>$2,500</td>
<td>Child under age 13; Older dependent incapable of self care</td>
</tr>
<tr>
<td>SINGLE HEAD OF HOUSEHOLD</td>
<td>$5,000</td>
<td>Child under age 13; Older dependent incapable of self care</td>
</tr>
<tr>
<td>MARRIED FILING JOINTLY</td>
<td>$5,000</td>
<td>Child under age 13; Older dependent incapable of self-care; Spouse incapable of self-care</td>
</tr>
</tbody>
</table>
VISA Benefits Debit Card

- Can be used to pay providers who accept VISA for eligible expenses for GPFSA, LPFSA and DCFSA
- Full amount of General-Purpose FSA and Limited-Purpose FSA funds are available immediately
- Dependent Care FSA funds are available upon deposit
- Card is reloadable each year as long as the employee reenrolls
- Card is replaced before expiration date

Discovery Benefits Contact Information:
- Phone: 1-866-451-3399
- Website: www.DiscoveryBenefits.com
- Fax: 1-866-451-3245
Mid-Year FSA Termination Notice

- Agency **must** send a termination notice to the contact below **on or before** the retirement date or the termination date of an employee who is participating in an FSA.

- The notice should include the first and last name, last four digits of SSN, date of termination, and the agency number of the termed/retired employee.

  - **OGB Flexible Benefits Administration**
    - Fax Number: 225-342-9919
    - Email: FlexibleSpendingAccounts@la.gov
Agency Checklist

FSA contribution payments and uploads to OFSS and DBI
(For Non-LaGov OGB FSA Participating Agencies ONLY)

After every pay period, FSA contributions must be reported to OGB-OFSS and also to Discovery Benefits, Inc. (DBI):

- To OGB-OFSS – for FSA payments by wire or by check, send an email to FlexibleSpendingAccounts@la.gov and DepositGroup@la.gov, and include the breakdown of Medical, Limited, Dependent Care FSA amounts and administrative fees.

- FSA payments by check, send to: Office of Group Benefits; Attn: FSA; P.O. Box 66678; Baton Rouge, LA 70896

- To DBI – the designated file agency contact with access to the SFTP portal will prepare the file, login, and submit the FSA contribution spreadsheet on the DBI template, and upload to DBI. DBI will post the contribution to the plan member’s file. If you do not use the DBI template to upload our FSA contributions, the FSA contributions will not get credited to the plan member.
Agency Checklist

- **New hires/newly-eligible employees**
  - Offer General-Purpose Health Care or Limited-Purpose Dental/Vision FSA
  - Offer Dependent-Care FSA
  - Enroll within 30 days of employee hire date

- **Transfers**
  - Pick up *same* deductions – no increase allowed
  - Pick up same annual elected amount for the remainder of the plan year

- **LWOP**
  - Notify OGB within 30 days of employee going on LWOP, along with reason for LWOP (FMLA, total and permanent disability, etc.)
  - Advise employees they may keep their insurance while on LWOP for up to 12 months provided they pay their applicable premium or they may drop it within 30 days of going on LWOP if they submit a GB-01 within 30 days
  - Employee may resume insurance by submitting a GB-01 within 30 days of return to work with pay

*Non-Medicare rehired retirees who are employed as active full-time employees are eligible for all options*
Statewide Products

Payroll systems participating in the Flexible Benefits Plan

During annual enrollment you may:

1. Enroll in a statewide product
2. Drop or add dependents
3. Discontinue a statewide product

Most Statewide Products’ are flexed/tax-saving benefits and cannot be canceled until the next annual enrollment period or you experience an OGB-Plan Recognized Qualified Life Event. Statewide products plan year begins January 1, 2019.

Please check with your human resources department about changing any Statewide benefits.
Wellness & Disease Management
Blue Cross and Blue Shield has a team of nurses, dietitians, social workers, and physicians that are available to meet your health and wellness needs. These team members work together to:

- Provide health coaching to help manage long-term health conditions, lower risks of serious complications, and support to reach health goals
- **Discounted copayments** for medications prescribed for diabetes, heart disease, heart failure, asthma and COPD when you participate
- Help with finding physicians, assist with coordinating your care, and serve as your advocates and advisors

Simply call **1(800) 363-9159** to speak with one of our health professionals today!
• Clinic information for the 2020 plan year discount will be forthcoming
  o Catapult will be at member meetings to begin enrolling members in clinics for the 2020 plan year discount
• Members must complete the process every year to receive the premium credit for the following plan year
  o Complete **one** step to qualify for annual premium discount:
    1. Schedule a wellness checkup through Catapult Health or see your MD for wellness visit and submit completed Primary Care Provider form
Introducing BlueCare

The doctor will see you anywhere, anytime.
Doctor visits online, on your time

BlueCare is:

- 24/7 - no appointment needed
- Open to you and any dependents (children, spouse, etc.) covered on your plan
- Faster than going to an ER or urgent care center
- Available on a computer, tablet, smartphone or any device with internet
- Secure and as legitimate as an in-person visit
Treat minor health conditions

- Sinus infections
- Cough or cold
- Rashes
- Allergies
- Bladder infections
- Pink eye
- Mild stomach bugs (throwing up, diarrhea)
Cost?

- Your maximum out-of-pocket cost will be $39.
- You may get some of that $39 back, depending on your health plan and whether you’ve met your deductible and other costs.
Go to www.bcbsla.com/BlueCare or get the BlueCare app for Android or iPhone.
Blue365
Join Blue365® for Health and Wellness Discounts!

Sign up for FREE!
Register at www.Blue365deals.com/BCBSLA for discounts from top-name national vendors.

Examples include:

• Exclusive $25/month membership to 9,000 gyms nationwide (with three-month commitment)
• 20% off all Reebok fitness gear, including shoes and apparel, plus free shipping
• 10-40% off Davis Vision products
• Discounts of 20-50% to a network of dentists
Omada
Diabetes Prevention Program
Diabetes Prevention Program

A WHOLE NEW WAY TO GET HEALTHY

Omada® is a breakthrough online program that inspires healthy habits you can live with long-term.

omadahealth.com/ogb
OMADA IS A HIGHLY CHOREOGRAPHED JOURNEY

Each component is made stronger by the others.

**smart technology**
Wireless scale, pedometer, and mobile apps track food, activity, and weight.

**interactive lessons**
Participants learn how to eat healthier, increase activity levels, and overcome challenges through fun lessons and games.

**full-time professional health coach**
A dedicated coach provides participants with real-time support and motivation.

**support group**
Participants are matched into peer groups for encouragement and healthy competition.

**data science**
We use rigorous scientific data analysis – in real-time – to determine exactly how to deliver the right personalized interventions, at the right time, to each individual participant, thereby deepening efficacy and outcomes at scale.

OMADA HEALTH
OMADA <> BLUE CROSS/OGB APPLICATION PAGE (omadahealth.com/ogb)
Quitter’s Circle® is a Digital Ecosystem That Includes a Website, Social Media Channels, and a Mobile App

Website:

Content includes tips and insights for both quitters and supporters

Social Media Channels:

Facebook and Twitter channels enable quitters to participate in a supportive community

Mobile App:

Allows users to:
• Develop a personalized Quit Plan with customized content based on individual progress
• Create a supportive Quit Team to motivate and keep track of their quit-smoking journey
Additional Features:

- **Key action reminder**: Push notifications prompt users to invite supporters, set a quit date, and schedule healthcare provider appointments.
- **Smoking and money saved log**: Allows users to keep track of their quit progress as well as their savings related to cigarette purchases.
- **Badges and certificates of completion**: Awarded for key milestones; awards can be shared with supporters on social media channels.
- **User surveys**: Assess quit progress at 30, 60, and 90 days.
- **Discussion guide**: An informational resource to help users prepare for a quit-smoking discussion with their healthcare provider.
- **Available on all Apple and Android mobile phones and smartwatches**.
Contact Information
OGB Agency Help Desk

Toll Free: (844) 860-0307
(For agency use only)

Baton Rouge Area: (225) 922-2401
(For agency use only)

Email: ogb.help@la.gov

Website: info.groupbenefits.org

OFSS: OFSS-OGB.Invoicing@la.gov
## Contact Information

<table>
<thead>
<tr>
<th>Blue Cross Blue Shield of Louisiana</th>
<th>Vantage Health Plan</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Peoples Health</th>
<th>Discovery Benefits</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MedImpact/VibrantRx</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ 1-800-788-2949 ✓ <a href="https://mp.medimpact.com/ogb">https://mp.medimpact.com/ogb</a></td>
<td></td>
</tr>
<tr>
<td>✓ 1-844-826-3451 ✓ <a href="http://www.myVibrantRx.com/OGB">www.myVibrantRx.com/OGB</a></td>
<td></td>
</tr>
</tbody>
</table>
Questions?