

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

HEALTH PLAN OPTION	PELICAN HRA1000 High Deductible Health Plan		PELICAN HSA775 High Deductible Health Plan	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE				
EMPLOYEE ONLY	\$2,000	\$4,000	\$2,000	\$4,000
FAMILY	\$4,000	\$8,000	\$4,000	\$8,000
OUT-OF-POCKET MAXIMUM				
EMPLOYEE ONLY	\$5,000	\$10,000	\$5,000	\$10,000
FAMILY	\$10,000	\$20,000	\$10,000	\$20,000
STATE FUNDING	THE PLAN PAYS		THE PLAN PAYS	
EMPLOYEE ONLY	\$1,000		\$775*	
FAMILY	\$2,000		\$775*	
	Funding not applicable to pharmacy Expenses.		*\$200, plus up to \$575 more dollar for dollar match of employee contributions	
COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
PHYSICIANS' SERVICES				
Preventative Care Primary Care Physician or Specialist Office or Clinic	100% coverage; not subject to deductible	100% of fee schedule amount. Plan participant pays the difference between the billed amount and the fee schedule amount; Not subject to deductible	100% coverage; not subject to deductible	100% of fee schedule amount. Plan participant pays the difference between the billed amount and the fee schedule amount; Not subject to deductible
Primary Care Physician or Specialist Office - Treatment of illness or injury	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Maternity Care (prenatal, delivery and postpartum)	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Physician Services Furnished in a Hospital Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist.	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Physician Services for Emergency Room Care	80% coverage; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible
Outpatient Surgery/ Services When billed as office visits	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/ Services When billed as outpatient surgery at a facility	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
HOSPITAL SERVICES				
Inpatient Services Inpatient care, delivery and inpatient short-term acute rehabilitation services	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/Services Hospital / Facility	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible

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

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COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
HOSPITAL SERVICES				
Emergency Room - Hospital (Facility)- Treatment of an emergency medical condition or injury	80% coverage; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible	80% coverage; subject to deductible
BEHAVIORAL HEALTH				
Mental Health and Substance Abuse - Inpatient Facility	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Mental Health and Substance Abuse Outpatient Visits - Professional	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
OTHER COVERAGE				
Outpatient Acute Short-Term Rehabilitation Services Physical Therapy, Speech Therapy, Occupational Therapy, etc.	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Chiropractic Care	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Urgent Care Center	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Home Health Care Services	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Skilled Nursing Facility Services	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Hospice Care	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Durable Medical Equipment (DME) - Rental or Purchase	80% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible
Hearing Aid Not covered for individuals age eighteen (18) and older	80% coverage; subject to deductible	NO COVERAGE	80% coverage; subject to deductible	NO COVERAGE
Transplant Services	80% coverage; subject to deductible	NO COVERAGE	80% coverage; subject to deductible	NO COVERAGE
PHARMACY				
Tier 1 - Generic	50% up to \$30 ¹		\$10 Copay	
Tier 2 - Preferred	50% up to \$55 ^{1,2}		\$25 copay	
Tier 3 - Non-Preferred	65% up to \$80 ^{1,2}		\$50 copay	
Tier 4 - Specialty	50% up to \$80 ^{1,2}		\$50 copay	
After the out-of-pocket threshold amount of \$1,500 is met by you and/or your covered dependent(s):				
Tier 1 - Generic	\$0 copay		Does Not Apply	
Tier 2 - Preferred	\$20 copay		Does Not Apply	
Tier 3 - Non-Preferred	\$40 copay		Does Not Apply	
Tier 4 - Specialty	\$40 copay		Does Not Apply	

¹Prescription drug benefit - 31-day fill

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

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

² Member who chooses brand-name drug for which approved generic version is available pays cost difference between brand-name drug & generic drug, plus copay for brand-name drug.; cost difference does not apply to \$1,500 out-of-pocket threshold (if applicable).

ACTIVE EMPLOYEES and NON-MEDICARE RETIREES
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Magnolia Health Plans Benefits Comparison
Benefits effective January 1, 2027 - December 31, 2027

HEALTH PLAN OPTION	MAGNOLIA LOCAL		MAGNOLIA LOCAL PLUS		MAGNOLIA OPEN ACCESS	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE						
EMPLOYEE ONLY	\$400	NO COVERAGE	\$400	NO COVERAGE	\$900	\$900
EMPLOYEE + 1	\$800	NO COVERAGE	\$800	NO COVERAGE	\$1,800	\$1,800
EMPLOYEE + 2 OR MORE	\$1,200	NO COVERAGE	\$1,200	NO COVERAGE	\$2,700	\$2,700
OUT-OF-POCKET MAXIMUM						
EMPLOYEE ONLY	\$2,500	NO COVERAGE	\$3,500	NO COVERAGE	\$3,500	\$4,700
EMPLOYEE + 1	\$5,000	NO COVERAGE	\$6,000	NO COVERAGE	\$6,000	\$8,500
EMPLOYEE + 2 OR MORE	\$7,500	NO COVERAGE	\$8,500	NO COVERAGE	\$8,500	\$12,250
COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
PHYSICIANS' SERVICES						
Preventative Care Primary Care Physician or Specialist Office or Clinic	100% coverage; not subject to deductible	NO COVERAGE	100% coverage; not subject to deductible	NO COVERAGE	100% coverage; not subject to deductible	70% coverage; subject to deductible
Primary Care Physician or Specialist Office - Treatment of illness or injury	100% coverage after a \$25 PCP or \$50 SPC copay per visit	NO COVERAGE	100% coverage after a \$25 PCP or \$50 SPC copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Maternity Care (prenatal, delivery and postpartum)	100% coverage; after a \$90 copay per pregnancy	NO COVERAGE	100% coverage; after a \$90 copay per pregnancy	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Physician Services Furnished in a Hospital Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist.	100% coverage; subject to deductible	NO COVERAGE	100% coverage; subject to deductible	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Physician Services for Emergency Room Care	100% coverage; subject to deductible	NO COVERAGE	100% coverage; subject to deductible	NO COVERAGE	90% coverage; subject to deductible	90% coverage; subject to deductible
Outpatient Surgery/ Services When billed as office visits	100% coverage; after a \$25 PCP or \$50 SPC copay per visit	NO COVERAGE	100% coverage; after a \$25 PCP or \$50 SPC copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Outpatient Surgery/ Services When billed as outpatient surgery at a facility	100% coverage; subject to deductible	NO COVERAGE	100% coverage; subject to deductible	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
HOSPITAL SERVICES						
Inpatient Services Inpatient care, delivery and inpatient short-term acute rehabilitation services	100% coverage; after a \$100 copay per day max \$300 per admission	NO COVERAGE	100% coverage; after a \$100 copay per day max \$300 per admission	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible + \$50 copay per day (days 1 - 50)
Outpatient Surgery/ Services Hospital / Facility	100% coverage; after a \$100 facility copay per visit	NO COVERAGE	100% coverage; after a \$100 facility copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible

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HEALTH PLAN OPTION	MAGNOLIA LOCAL		MAGNOLIA LOCAL PLUS		MAGNOLIA OPEN ACCESS	
COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
HOSPITAL SERVICES						
Emergency Room - Hospital (Facility) Treatment of an emergency medical condition or injury	100% coverage after \$200 copay per visit; waived if admitted	NO COVERAGE	100% coverage after \$200 copay per visit; waived if admitted	NO COVERAGE	90% coverage; subject to deductible; \$200 copay per visit; waived if admitted	90% coverage; subject to deductible; \$200 copay per visit; waived if admitted
BEHAVIORAL HEALTH						
Mental Health and Substance Abuse Inpatient Facility	100% coverage; after a \$100 copay per day max \$300 per admission	NO COVERAGE	100% coverage; after a \$100 copay per day max \$300 per admission	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible + \$50 copay per day (days -5)
Mental Health and Substance Abuse Outpatient Visits - Professional	100% coverage; after a \$25 copay per visit	NO COVERAGE	100% coverage; after a \$25 copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
OTHER COVERAGE						
Outpatient Acute Short-Term Rehabilitation Services Physical Therapy, Speech Therapy, Occupational Therapy, Other short term rehabilitative services	100% coverage; after a \$25 copay per visit	NO COVERAGE	100% coverage; after a \$25 copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Chiropractic Care	100% coverage; after a \$25 copay per visit	NO COVERAGE	100% coverage; after a \$25 copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Urgent Care Center	100% coverage after a \$50 copay per visit	NO COVERAGE	100% coverage after a \$50 copay per visit	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Home Health Care Services	100% coverage subject to deductible	NO COVERAGE	100% coverage subject to deductible	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Skilled Nursing Facility Services	100% coverage; after a \$100 copay per day max \$300 per admission	NO COVERAGE	100% coverage; after a \$100 copay per day max \$300 per admission	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Hospice Care	100% coverage subject to deductible	NO COVERAGE	100% coverage subject to deductible	NO COVERAGE	80% coverage; subject to deductible	70% coverage; subject to deductible
Durable Medical Equipment (DME) - Rental or Purchase	80% coverage of the first \$5,000 allowable; subject to deductible; 100% in excess of \$5,000 per plan year	NO COVERAGE	80% coverage of the first \$5,000 allowable; subject to deductible; 100% in excess of \$5,000 per plan year	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible

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COVERED SERVICES	IN-NETWORK	OUT-OF-NET- WORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
OTHER COVERAGE						
Hearing Aid Not covered for individuals age eighteen (18) and older	80% coverage; subject to deductible	NO COVERAGE	80% coverage; subject to deductible	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
Transplant Services	100% coverage; subject to deductible	NO COVERAGE	100% coverage; subject to deductible	NO COVERAGE	90% coverage; subject to deductible	70% coverage; subject to deductible
PHARMACY						
Tier 1 - Generic	50% up to \$30 ¹					
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Tier 3 - Non-Preferred	65% up to \$80 ^{1,2}					
Tier 4 - Specialty	50% up to \$80 ^{1,2}					
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Tier 3 - Non-Preferred	\$40 copay					
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