

NON-MEDICARE RETIREES
(RETIREMENT DATE BEFORE 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	
	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
EMPLOYEE ONLY	\$2,000	\$4,000
FAMILY	\$4,000	\$8,000
OUT-OF-POCKET MAXIMUM		
EMPLOYEE ONLY	\$5,000	\$10,000
FAMILY	\$10,000	\$20,000
STATE FUNDING	THE PLAN PAYS	
EMPLOYEE ONLY	\$1,000	
FAMILY	\$2,000	
	Funding not applicable to pharmacy Expenses.	
COVERED SERVICES	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
Primary Care Physician or Specialist Office - Treatment of illness or injury	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
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
Physician Services for Emergency Room Care	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
Outpatient Surgery/ Services When billed as outpatient surgery at a facility	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
Outpatient Surgery/Services Hospital / Facility	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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HOSPITAL SERVICES		
Emergency Room - Hospital (Facility) Treatment of an emergency medical condition or injury	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
Mental Health and Substance Abuse Outpatient Visits - Professional	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
Chiropractic Care	80% coverage; subject to deductible	60% coverage; subject to deductible
Urgent Care Center	80% coverage; subject to deductible	60% coverage; subject to deductible
Home Health Care Services	80% coverage; subject to deductible	60% coverage; subject to deductible
Skilled Nursing Facility Services	80% coverage; subject to deductible	60% coverage; subject to deductible
Hospice Care	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
Hearing Aid Not covered for individuals age eighteen (18) and older	80% coverage; subject to deductible	NO COVERAGE
Transplant Services	80% coverage; subject to deductible	NO COVERAGE
PHARMACY		
Tier 1 - Generic	50% up to \$30 ¹	
Tier 2 - Preferred	50% up to \$55 ^{1,2}	
Tier 3 - Non-Preferred	65% up to \$80 ^{1,2}	
Tier 4 - Specialty	50% up to \$80 ^{1,2}	
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	
Tier 2 - Preferred	\$20 copay	
Tier 3 - Non-Preferred	\$40 copay	
Tier 4 - Specialty	\$40 copay	

¹ Prescription drug benefit - 31-day fil

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).

NON-MEDICARE RETIREES
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Magnolia Health Plans Benefits Comparison
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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	\$0	NO COVERAGE	\$0	NO COVERAGE	\$300	
EMPLOYEE + 1	\$0	NO COVERAGE	\$0	NO COVERAGE	\$600	
EMPLOYEE + 2 OR MORE	\$0	NO COVERAGE	\$0	NO COVERAGE	\$900	
OUT-OF-POCKET MAXIMUM						
EMPLOYEE ONLY	\$1,000	NO COVERAGE	\$2,000	NO COVERAGE	\$2,300	\$4,300
EMPLOYEE + 1	\$2,000	NO COVERAGE	\$3,000	NO COVERAGE	\$3,600	\$7,600
EMPLOYEE + 2 OR MORE	\$3,000	NO COVERAGE	\$4,000	NO COVERAGE	\$4,900	\$10,900
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 de- ductible
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)

PCP = Primary Care Provider; SPC = Specialist

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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						
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
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 1-5)
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 reha- bitative 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 de- ductible
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

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COVERED SERVICES	IN-NETWORK	OUT-OF-NET- WORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
OTHER COVERAGE						
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
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
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