

Non-Medicare Retirees
(RETIREMENT DATE BEFORE March 1, 2015)
Pelican Health Plans Benefits Comparison
Benefits effective January 1, 2025 - December 31, 2025

| HEALTH PLAN OPTION | PELICAN HRA 1000 High Deductible Health Plan | |
|---|--|--|
| NETWORK | Louisiana Blue Preferred Care Provider & Blue Cross National Providers | |
| | IN-NETWORK | OUT-OF-NETWORK |
| DEDUCTIBLE | | |
| RETIREE ONLY | \$2,000 | \$4,000 |
| FAMILY | \$4,000 | \$8,000 |
| OUT-OF-POCKET MAXIMUM | | |
| RETIREE ONLY | \$5,000 | \$10,000 |
| FAMILY | \$10,000 | \$20,000 |
| STATE FUNDING | | |
| | THE PLAN PAYS | |
| EMPLOYEE ONLY | \$1,000 | |
| FAMILY | \$2,000 | |
| | HRA 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.

Non-Medicare Retirees
(RETIREMENT DATE BEFORE March 1, 2015)
Pelican Health Plans Benefits Comparison
Benefits effective January 1, 2025 - December 31, 2025

| HEALTH PLAN OPTION | PELICAN HRA1000 High Deductible Health Plan | |
|--|--|--|
| NETWORK | Louisiana Blue Preferred Care Provider & Blue Cross National Providers | |
| COVERED SERVICES | 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 |
| 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, Other short term rehabilitative services | 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 fill

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
(RETIREMENT DATE BEFORE March 1, 2015)
Magnolia Health Plans Benefits Comparison
Benefits effective January 1, 2025 - December 31, 2025

| HEALTH PLAN OPTION | MAGNOLIA LOCAL | | MAGNOLIA LOCAL PLUS | | MAGNOLIA OPEN ACCESS | |
|--|--|--|--|--|--|--|
| NETWORK | Louisiana Blue Community Blue & Blue Connect Providers | | Louisiana Blue Preferred Care Provider & Blue Cross National Providers | | Louisiana Blue Preferred Care Provider & Blue Cross National Providers | |
| | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK |
| DEDUCTIBLE | | | | | | |
| RETIREE ONLY | \$0 | NO COVERAGE | \$0 | NO COVERAGE | \$300 | |
| RETIREE + 1 | \$0 | NO COVERAGE | \$0 | NO COVERAGE | \$600 | |
| RETIREE + 2 OR MORE | \$0 | NO COVERAGE | \$0 | NO COVERAGE | \$900 | |
| OUT-OF-POCKET MAXIMUM | | | | | | |
| RETIREE ONLY | \$1,000 | NO COVERAGE | \$2,000 | NO COVERAGE | \$2,300 | \$4,300 |
| RETIREE + 1 | \$2,000 | NO COVERAGE | \$3,000 | NO COVERAGE | \$3,600 | \$7,600 |
| RETIREE + 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 deductible |
| Primary Care Physician or Specialist Office - Treatment of illness or injury | 100% coverage after a \$25 PCP or \$50 SPC copay | NO COVERAGE | 100% coverage after a \$25 PCP or \$50 SPC copay | 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 | 100% coverage; subject to deductible | 100% coverage; subject to deductible | 100% coverage; subject to deductible | 90% coverage; subject to deductible | 90% coverage; subject to deductible |
| Outpatient Surgery/ Services When billed as office visit | 100% coverage; after a \$25 PCP or \$50 SPC copay | NO COVERAGE | 100% coverage; after a \$25 PCP or \$50 SPC copay | 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) |

Non-Medicare Retirees
(RETIREMENT DATE BEFORE March 1, 2015)
Magnolia Health Plans Benefits Comparison
Benefits effective January 1, 2025 - December 31, 2025

| HEALTH PLAN OPTION | MAGNOLIA LOCAL | | MAGNOLIA LOCAL PLUS | | MAGNOLIA OPEN ACCESS | |
|--|---|---|--|--|---|---|
| NETWORK | Louisiana Blue Community Blue & Blue Connect Providers | | Louisiana Blue Preferred Care Provider & Blue Cross National Providers | | Louisiana Blue Preferred Care Provider & Blue Cross National Providers | |
| 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 | 100% coverage after \$200 copay per visit; waived if admitted | 100% coverage after \$200 copay per visit; waived if admitted | 100% coverage after \$200 copay per visit; waived if admitted | 90% coverage; 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 | | 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 | | 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) |
| 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 |
| 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 |

Non-Medicare Retirees
(RETIREMENT DATE BEFORE March 1, 2015)
Magnolia Health Plans Benefits Comparison
Benefits effective January 1, 2025 - December 31, 2025

| HEALTH PLAN OPTION | MAGNOLIA LOCAL | | MAGNOLIA LOCAL PLUS | | MAGNOLIA OPEN ACCESS | |
|--|---|-----------------------|---|-----------------------|--|-------------------------------------|
| NETWORK | Louisiana Blue Community Blue & Blue Connect Providers | | Louisiana Blue Preferred Care Provider & Blue Cross National Providers | | Louisiana Blue Preferred Care Provider & Blue Cross National Providers | |
| COVERED SERVICES | IN-NETWORK | OUT-OF-NETWORK | 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 |
| 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 | | | | | |
| 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 fill

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).

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.