# Rehired 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 | | PELICAN HSA775 High Deductible Health Plan | |
|---|---|---|---|---|
| **NETWORK** | 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 |
| **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[5] | |
| **COVERED SERVICES** | **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.

[3] PCP = Primary Care Provider; SPC = Specialist

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| HEALTH PLAN OPTION | PELICAN HRA1000 High Deductible Health Plan | | PELICAN HSA775 High Deductible Health Plan | |
|---|---|---|---|---|
| **NETWORK** | 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** |
| **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; subject to deductible [1] | |
| **Tier 2 - Preferred** | 50% up to $55 [1,2] | | $25; subject to deductible [1] | |
| **Tier 3 - Non-Preferred** | 65% up to $80 [1,2] | | $50; subject to deductible [1] | |
| **Tier 4 - Specialty** | 50% up to $80 [1,2] | | $50; subject to deductible [1] | |
| **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 | | Not Applicable | |
| **Tier 2 - Preferred** | $20 copay | | Not Applicable | |
| **Tier 3 - Non-Preferred** | $40 copay | | Not Applicable | |
| **Tier 4 - Specialty** | $40 copay | | Not Applicable | |

[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).

** For a complete list of maintenance medications visit: https://lablue.com/ogb/pelican-hsa-775-active-employees

# Rehired 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 Preferred Care Provider & Blue Cross National 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** | | | | | | |
| 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 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) |

# 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 Preferred Care Provider & Blue Cross National 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 | 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 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 + $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 |

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| HEALTH PLAN OPTION | MAGNOLIA LOCAL | | MAGNOLIA LOCAL PLUS | | MAGNOLIA OPEN ACCESS | |
|---|---|---|---|---|---|---|
| **NETWORK** | Louisiana Blue Preferred Care Provider & Blue Cross National 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 |
| **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] | | | | | |
| **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.