ACTIVE EMPLOYEES and NON-MEDICARE RETIREES
(RETIREMENT DATE ON or AFTER March 1, 2015)
Pelican Health Plans Benefits Comparison
Benefits effective January 1, 2026 - December 31, 2026

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	
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.

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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]		50% up to $30 [1]	
Tier 2 - Preferred	50% up to $55 [1,2]		50% up to $55 [1,2]	
Tier 3 - Non-Preferred	65% up to $80 [1,2]		65% up to $80 [1,2]	
Tier 4 - Specialty	50% up to $80 [1,2]		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		$0 copay	
Tier 2 - Preferred	$20 copay		$20 copay	
Tier 3 - Non-Preferred	$40 copay		$40 copay	
Tier 4 - Specialty	$40 copay		$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).

ACTIVE EMPLOYEES and NON-MEDICARE RETIREES
(RETIREMENT DATE ON or AFTER March 1, 2015)
Magnolia Health Plans Benefits Comparison
Benefits effective January 1, 2026 - December 31, 2026

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						
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	
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						
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 isit	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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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						
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).

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