Medicare Retirees
(RETIREMENT DATE BEFORE March 1, 2015)
Pelican Health Plans Benefits Comparison
Benefits effective January 1, 2026 - December 31, 2026

HEALTH PLAN OPTION	PELICAN HRA1000	
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
MEDICAL OUT-OF-POCKET MAXIMUM - APPLIES TO EACH COVERED PERSON		
RETIREE ONLY	$3,000	$10,000
FAMILY (Medicare Paying Primary for ONE)	$8,000	$20,000
FAMILY (Medicare Paying Primary for TWO)	$6,000	$20,000
FAMILY (Medicare Paying Primary for THREE)	$4,000	$20,000
PRESCRIPTION OUT-OF-POCKET MAXIMUM - APPLIES TO EACH COVERED PERSON		
EACH COVERED PERSON	$2,000	
STATE FUNDING	**THE PLAN PAYS**	
RETIREE 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 visit	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

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	
NETWORK	Louisiana Blue Preferred Care Provider & Blue Cross National Providers	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
HOSPITAL SERVICES		
Outpatient Surgery/Services Hospital / Facility	80% coverage; subject to deductible	60% coverage; subject to deductible
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).

Medicare Retirees
(RETIREMENT DATE BEFORE 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						
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	
MEDICAL OUT-OF-POCKET MAXIMUM - MEDICARE PRIMARY PAYER FOR AT LEAST ONE PARTICIPANT						
RETIREE ONLY	$0	NO COVERAGE	$500	NO COVERAGE	$1,300	
RETIREE + 1	$1,000	NO COVERAGE	$1,500	NO COVERAGE	$3,600	
RETIREE + 2 OR MORE	$2,000	NO COVERAGE	$2,500	NO COVERAGE	$5,900	
MEDICAL OUT-OF-POCKET MAXIMUM - MEDICARE PRIMARY PAYER FOR AT LEAST TWO PARTICIPANTS						
RETIREE + 1	$0	NO COVERAGE	$0	NO COVERAGE	$1,600	
RETIREE + 2 OR MORE	$1,000	NO COVERAGE	$1,500	NO COVERAGE	$3,900	
MEDICAL OUT-OF-POCKET MAXIMUM - MEDICARE PRIMARY PAYER FOR AT LEAST THREE PARTICIPANTS						
RETIREE + 2 OR MORE	$0	NO COVERAGE	$0	NO COVERAGE	$1,900	
PRESCRIPTION OUT-OF-POCKET MAXIMUM - APPLIES TO EACH COVERED PERSON						
EACH COVERED PERSON	$1,000		$1,500		$2,000	
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 For a complete list of benefits, refer to the Preventive and Wellness/ Routine	100% coverage; not subject to deductible	NO COVERAGE	100% coverage; not subject to deductible	NO COVERAGE	100% coverage; not subject to deductible	80% 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	80% coverage; subject to deductible	80% 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	80% coverage; subject to deductible	80% 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	80% coverage; subject to deductible	80% coverage; subject to deductible

PCP = Primary Care Provider; SPC = Specialist

Medicare Retirees
(RETIREMENT DATE BEFORE 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	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICIANS' SERVICES						
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	80% coverage; subject to deductible	80% 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	80% coverage; subject to deductible	80% 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	80% coverage; subject to deductible	80% coverage; subject to deductible
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	80% coverage; subject to deductible	80% 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	80% coverage; subject to deductible; $200 copay per visit; waived if admitted	80% 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	80% coverage; subject to deductible	80% coverage; subject to deductible
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	80% coverage; subject to deductible	80% 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	80% coverage; subject to deductible	80% 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	80% coverage; subject to deductible	80% 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						
Urgent Care Center	100% coverage after a $50 copay per visit	NO COVERAGE	100% coverage after a $50 copay per visit	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
Home Health Care Services	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE
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	80% coverage; subject to deductible	80% coverage; subject to deductible
Hospice Care	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO 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	80% coverage; subject to deductible	80% 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	80% coverage; subject to deductible	80% coverage; subject to deductible
Transplant Services	100% coverage; subject to deductible	NO COVERAGE	100% coverage; subject to deductible	NO COVERAGE	80% coverage; subject to deductible	80% 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					

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[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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