

**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	
<b>NETWORK</b>	Louisiana Blue Preferred Care Provider & Blue Cross National Providers	
	IN-NETWORK	OUT-OF-NETWORK
<b>DEDUCTIBLE</b>		
RETIREE ONLY	\$2,000	\$4,000
FAMILY	\$4,000	\$8,000
<b>MEDICAL OUT-OF-POCKET MAXIMUM - APPLIES TO EACH COVERED PERSON</b>		
RETIREE ONLY	\$3,000	\$10,000
FAMILY (MEDICARE PRIMARY PAYER ON AT LEAST ONE )	\$8,000	\$20,000
FAMILY (MEDICARE PRIMARY PAYER ON AT LEAST TWO )	\$6,000	\$20,000
FAMILY (MEDICARE PRIMARY PAYER ON AT LEAST THREE )	\$4,000	\$20,000
<b>PRESCRIPTION OUT-OF-POCKET MAXIMUM - APPLIES TO EACH COVERED PERSON</b>		
EACH COVERED PERSON	\$2,000	
<b>STATE FUNDING</b>		
	<b>THE PLAN PAYS</b>	
RETIREE ONLY	<b>\$1,000</b>	
FAMILY	<b>\$2,000</b>	
	Funding not applicable to pharmacy Expenses.	
COVERED SERVICES	IN-NETWORK	OUT OF-NETWORK
<b>PHYSICIANS' SERVICES</b>		
<b>Preventative Care</b> <b>Primary Care Physician or Specialist Office or Clinic</b> For a complete list of benefits, refer to the Preventive and Wellness/Routine	100% coverage; <b>not</b> subject to deductible	100% of fee schedule amount. Plan participant pays the difference between the billed amount and the fee schedule amount; <b>Not</b> subject to deductible
<b>Primary Care Physician or Specialist Office -</b> Treatment of illness or injury	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Maternity Care</b> (prenatal, delivery and postpartum)	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Physician Services Furnished in a Hospital</b> Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist.	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Physician Services for Emergency Room Care</b>	80% coverage; subject to deductible	80% coverage; subject to deductible
<b>Outpatient Surgery/ Services</b> When billed as office visits	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Outpatient Surgery/ Services</b> When billed as outpatient surgery at a facility	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>HOSPITAL SERVICES</b>		
<b>Inpatient Services</b> Inpatient care, delivery and inpatient short-term acute rehabilitation services	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Outpatient Surgery/Services</b> Hospital / Facility	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Emergency Room - Hospital (Facility)</b> Treatment of an emergency medical condition or injury	80% coverage; subject to deductible	80% coverage; subject to deductible

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HEALTH PLAN OPTION	PELICAN HRA1000 High Deductible Plan	
<b>NETWORK</b>	Louisiana Blue Preferred Care Provider & Blue Cross National Providers	
COVERED SERVICES	IN-NETWORK	OUT OF-NETWORK
BEHAVIORAL HEALTH		
<b>Mental Health and Substance Abuse</b> Inpatient Facility	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Mental Health and Substance Abuse Outpatient Visits - Professional</b>	80% coverage; subject to deductible	60% coverage; subject to deductible
OTHER COVERAGE		
<b>Outpatient Acute Short-Term Rehabilitation Services</b> Physical Therapy, Speech Therapy, Occupational Therapy, Other short term rehabilitative services	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Chiropractic Care</b>	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Urgent Care Center</b>	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Home Health Care Services</b>	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Skilled Nursing Facility Services</b>	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Hospice Care</b>	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Durable Medical Equipment (DME) - Rental or Purchase</b>	80% coverage; subject to deductible	60% coverage; subject to deductible
<b>Hearing Aid</b> Not covered for individuals age eighteen (18) and older	80% coverage; subject to deductible	NO COVERAGE
<b>Transplant Services</b>	80% coverage; subject to deductible	NO COVERAGE
PHARMACY		
<b>Tier 1 - Generic</b>	50% up to \$30 <sup>1</sup>	
<b>Tier 2 - Preferred</b>	50% up to \$55 <sup>1,2</sup>	
<b>Tier 3 - Non-Preferred</b>	65% up to \$80 <sup>1,2</sup>	
<b>Tier 4 - Specialty</b>	50% up to \$80 <sup>1,2</sup>	
After the out-of-pocket threshold amount of \$1,500 is met by you and/or your covered dependent(s):		
<b>Tier 1 - Generic</b>	\$0 copay	
<b>Tier 2 - Preferred</b>	\$20 copay	
<b>Tier 3 - Non-Preferred</b>	\$40 copay	
<b>Tier 4 - Specialty</b>	\$40 copay	

<sup>1</sup> Prescription drug benefit - 31-day fill

<sup>2</sup> 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.

**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
<b>DEDUCTIBLE</b>						
RETIREE ONLY	\$400	NO COVERAGE	\$400	NO COVERAGE	\$900	\$900
RETIREE + 1	\$800	NO COVERAGE	\$800	NO COVERAGE	\$1,800	\$1,800
RETIREE + 2 OR MORE	\$1,200	NO COVERAGE	\$1,200	NO COVERAGE	\$2,700	\$2,700
<b>MEDICAL OUT-OF-POCKET MAXIMUM -MEDICARE PRIMARY PAYER FOR AT LEAST ONE PARTICIPANT</b>						
RETIREE	\$500	NO COVERAGE	\$1,500	NO COVERAGE	\$1,500	\$4,700
RETIREE + 1	\$3,000	NO COVERAGE	\$4,000	NO COVERAGE	\$4,000	\$8,500
RETIREE + 2 OR MORE	\$5,500	NO COVERAGE	\$6,500	NO COVERAGE	\$6,500	\$12,250
<b>MEDICAL OUT-OF-POCKET MAXIMUM -MEDICARE PRIMARY PAYER FOR AT LEAST TWO PARTICIPANTS</b>						
RETIREE + 1	\$1,000	NO COVERAGE	\$2,000	NO COVERAGE	\$2,000	\$8,500
RETIREE + 2 OR MORE	\$3,500	NO COVERAGE	\$4,000	NO COVERAGE	\$4,500	\$12,250
<b>MEDICAL OUT-OF-POCKET MAXIMUM -MEDICARE PRIMARY PAYER FOR AT LEAST THREE PARTICIPANTS</b>						
RETIREE + 2 OR MORE	\$1,500	NO COVERAGE	\$2,500	NO COVERAGE	\$2,500	\$12,250
<b>PRESCRIPTION OUT-OF-POCKET MAXIMUM -APPLIES TO EACH COVERED PERSON</b>						
EACH COVERED PERSON	\$2,000		\$2,000		\$2,000	
COVERED SERVICES	IN-NETWORK	OUT OF-NETWORK	IN-NETWORK	OUT OF-NETWORK	IN-NETWORK	OUT OF-NETWORK
<b>PHYSICIANS' SERVICES</b>						
<b>Preventative Care Primary Care Physician or Specialist Office or Clinic</b> For a complete list of benefits, refer to the Preventive and Wellness/ Routine	100% coverage	NO COVERAGE	100% coverage	NO COVERAGE	100% coverage; not subject to deductible	80% coverage; subject to deductible
<b>Primary Care Physician or Specialist Office - Treatment of illness or injury</b>	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
<b>Maternity Care</b> (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
<b>Physician Services Furnished in a Hospital</b> Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist.	100% coverage	NO COVERAGE	100% coverage	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
<b>Physician Services for Emergency Room Care</b>	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

PCP = Primary Care Provider; SPC = Specialist

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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
<b>PHYSICIANS' SERVICES</b>						
<b>Outpatient Surgery/ Services</b> 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
<b>Outpatient Surgery/ Services</b> When billed as outpatient surgery at a facility	100% coverage	NO COVERAGE	100% coverage	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
<b>HOSPITAL SERVICES</b>						
<b>Inpatient Services</b> 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 + \$50 copay per day (days 1 - 50)
<b>Outpatient Surgery/ Services</b> 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
<b>Emergency Room - Hospital (Facility)</b> 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
<b>BEHAVIORAL HEALTH</b>						
<b>Mental Health and Substance Abuse</b> 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 + \$50 copay per day (days -5)
<b>Mental Health and Substance Abuse Outpatient Visits - Professional</b>	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
<b>OTHER COVERAGE</b>						
<b>Outpatient Acute Short-Term Rehabilitation Services</b> 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
<b>Chiropractic Care</b>	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

PCP = Primary Care Provider; SPC = Specialist

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<b>NETWORK</b>	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	
<b>COVERED SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT OF-NETWORK</b>	<b>IN-NETWORK</b>	<b>OUT OF-NETWORK</b>	<b>IN-NETWORK</b>	<b>OUT OF-NETWORK</b>
<b>OTHER COVERAGE</b>						
<b>Urgent Care Center</b>	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
<b>Home Health Care Services</b>	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE
<b>Skilled Nursing Facility Services</b>	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 + \$50 copay per day (days 1 - 50)
<b>Hospice Care</b>	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE	NO COVERAGE
<b>Durable Medical Equipment (DME) - Rental or Purchase</b>	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
<b>Hearing Aid</b> 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
<b>Transplant Services</b>	100% coverage	NO COVERAGE	100% coverage	NO COVERAGE	80% coverage; subject to deductible	80% coverage; subject to deductible
<b>PHARMACY</b>						
<b>Tier 1 - Generic</b>	50% up to \$30 <sup>1</sup>					
<b>Tier 2 - Preferred</b>	50% up to \$55 <sup>1,2</sup>					
<b>Tier 3 - Non-Preferred</b>	65% up to \$80 <sup>1,2</sup>					
<b>Tier 4 - Specialty</b>	50% up to \$80 <sup>1,2</sup>					
<b>After the out-of-pocket threshold amount of \$1,500 is met by you and/or your covered dependent(s):</b>						
<b>Tier 1 - Generic</b>	\$0 copay					
<b>Tier 2 - Preferred</b>	\$20 copay					
<b>Tier 3 - Non-Preferred</b>	\$40 copay					
<b>Tier 4 - Specialty</b>	\$40 copay					

<sup>1</sup> Prescription drug benefit - 31-day fill

<sup>2</sup> 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.