

**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<br>High Deductible Health Plan                               |  | PELICAN HSA775<br>High Deductible Health Plan                                   |   |
|---|--|--|---|---|
| <b>NETWORK</b>  | Louisiana Blue<br>Preferred Care Provider &<br>Blue Cross National Providers |  | Louisiana Blue<br>Preferred Care Provider &<br>Blue Cross National Providers    |   |
|   | IN-NETWORK   | OUT-OF-NETWORK   | IN-NETWORK  | OUT-OF-NETWORK  |
| <b>DEDUCTIBLE</b>   |  |  |   |   |
| EMPLOYEE ONLY   | \$2,000  | \$4,000  | \$2,000   | \$4,000   |
| FAMILY  | \$4,000  | \$8,000  | \$4,000   | \$8,000   |
| <b>OUT-OF-POCKET MAXIMUM</b>  |  |  |   |   |
| EMPLOYEE ONLY   | \$5,000  | \$10,000   | \$5,000   | \$10,000  |
| FAMILY  | \$10,000   | \$20,000   | \$10,000  | \$20,000  |
| <b>STATE FUNDING</b>  | <b>THE PLAN PAYS</b>   |  | <b>THE PLAN PAYS</b>  |   |
| 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 |   |
| <b>COVERED SERVICES</b>   | IN-NETWORK   | OUT-OF-NETWORK   | IN-NETWORK  | OUT-OF-NETWORK  |
| <b>PHYSICIANS' SERVICES</b>   |  |  |   |   |
| <b>Preventative Care<br/>Primary Care Physician or<br/>Specialist Office or Clinic</b>  | 100% coverage;<br><b>not</b> subject to deductible                           | 100% of fee schedule amount.<br>Plan participant pays the difference between the billed amount and the fee schedule amount; <b>Not</b> subject to deductible | 100% coverage;<br><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 -<br/>Treatment of illness or injury</b>   | 80% coverage;<br>subject to deductible                                       | 60% coverage; subject to deductible  | 80% coverage; subject to deductible   | 60% coverage; subject to deductible   |
| <b>Maternity Care<br/>(prenatal, delivery and postpartum)</b>   | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible   | 80% coverage;<br>subject to deductible  | 60% coverage;<br>subject to deductible  |
| <b>Physician Services Furnished in a Hospital</b><br>Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist. | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible   | 80% coverage;<br>subject to deductible  | 60% coverage;<br>subject to deductible  |
| <b>Physician Services for Emergency Room Care</b>   | 80% coverage;<br>subject to deductible                                       | 80% coverage;<br>subject to deductible   | 80% coverage;<br>subject to deductible  | 80% coverage;<br>subject to deductible  |
| <b>Outpatient Surgery/ Services<br/>When billed as office visits</b>  | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible   | 80% coverage;<br>subject to deductible  | 60% coverage;<br>subject to deductible  |
| <b>Outpatient Surgery/ Services<br/>When billed as outpatient surgery at a facility</b>   | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible   | 80% coverage;<br>subject to deductible  | 60% coverage;<br>subject to deductible  |
| <b>HOSPITAL SERVICES</b>  |  |  |   |   |
| <b>Inpatient Services</b><br>Inpatient care, delivery and inpatient short-term acute rehabilitation services  | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible   | 80% coverage;<br>subject to deductible  | 60% coverage;<br>subject to deductible  |
| <b>Outpatient Surgery/Services<br/>Hospital / Facility</b>  | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible   | 80% coverage;<br>subject to deductible  | 60% coverage;<br>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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|--|--|--|--|--|
| NETWORK  | Louisiana Blue<br>Preferred Care Provider &<br>Blue Cross National Providers |  | Louisiana Blue<br>Preferred Care Provider &<br>Blue Cross National Providers |  |
| COVERED SERVICES   | IN-NETWORK   | OUT-OF-NETWORK                         | IN-NETWORK   | OUT-OF-NETWORK                         |
| <b>HOSPITAL SERVICES</b>   |  |  |  |  |
| <b>Emergency Room - Hospital (Facility)</b> - Treatment of an emergency medical condition or injury                        | 80% coverage;<br>subject to deductible                                       | 80% coverage;<br>subject to deductible | 80% coverage;<br>subject to deductible                                       | 80% coverage;<br>subject to deductible |
| <b>BEHAVIORAL HEALTH</b>   |  |  |  |  |
| <b>Mental Health and Substance Abuse</b> - Inpatient Facility  | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible |
| <b>Mental Health and Substance Abuse Outpatient Visits</b> - Professional  | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible |
| <b>OTHER COVERAGE</b>  |  |  |  |  |
| <b>Outpatient Acute Short-Term Rehabilitation Services</b><br>Physical Therapy, Speech Therapy, Occupational Therapy, etc. | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible |
| <b>Chiropractic Care</b>   | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible |
| <b>Urgent Care Center</b>  | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible |
| <b>Home Health Care Services</b>   | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible |
| <b>Skilled Nursing Facility Services</b>   | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible |
| <b>Hospice Care</b>  | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible |
| <b>Durable Medical Equipment (DME) - Rental or Purchase</b>  | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible | 80% coverage;<br>subject to deductible                                       | 60% coverage;<br>subject to deductible |
| <b>Hearing Aid</b><br>Not covered for individuals age eighteen (18) and older  | 80% coverage;<br>subject to deductible                                       | NO COVERAGE                            | 80% coverage;<br>subject to deductible                                       | NO COVERAGE                            |
| <b>Transplant Services</b>   | 80% coverage;<br>subject to deductible                                       | NO COVERAGE                            | 80% coverage;<br>subject to deductible                                       | NO COVERAGE                            |
| <b>PHARMACY</b>  |  |  |  |  |
| <b>Tier 1 - Generic</b>  | 50% up to \$30 <sup>1</sup>  |  | \$10 copay   |  |
| <b>Tier 2 - Preferred</b>  | 50% up to \$55 <sup>1,2</sup>  |  | \$25 copay   |  |
| <b>Tier 3 - Non-Preferred</b>  | 65% up to \$80 <sup>1,2</sup>  |  | \$50 copay   |  |
| <b>Tier 4 - Specialty</b>  | 50% up to \$80 <sup>1,2</sup>  |  | \$50 copay   |  |
| <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  |  | Not Applicable   |  |
| <b>Tier 2 - Preferred</b>  | \$20 copay   |  | Not Applicable   |  |
| <b>Tier 3 - Non-Preferred</b>  | \$40 copay   |  | Not Applicable   |  |
| <b>Tier 4 - Specialty</b>  | \$40 copay   |  | Not Applicable   |  |

<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).

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| HEALTH PLAN OPTION  | MAGNOLIA LOCAL  |                | MAGNOLIA LOCAL PLUS  |                | MAGNOLIA OPEN ACCESS   |   |
|---|---|----------------|--|----------------|--|---|
| NETWORK   | Louisiana Blue<br>Community Blue & Blue Connect Providers             |                | Louisiana Blue<br>Preferred Care Provider &<br>Blue Cross National Providers |                | Louisiana Blue<br>Preferred Care Provider &<br>Blue Cross National Providers |   |
|   | IN-NETWORK  | OUT-OF-NETWORK | IN-NETWORK   | OUT-OF-NETWORK | IN-NETWORK   | OUT-OF-NETWORK  |
| <b>DEDUCTIBLE</b>   |   |                |  |                |  |   |
| 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   |
| <b>OUT-OF-POCKET MAXIMUM</b>  |   |                |  |                |  |   |
| 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  |
| <b>PHYSICIANS' SERVICES</b>   |   |                |  |                |  |   |
| <b>Preventative Care</b><br><b>Primary Care Physician or Specialist Office or Clinic</b>  | 100% coverage;<br>not subject to deductible                           | NO COVERAGE    | 100% coverage;<br>not subject to deductible                                  | NO COVERAGE    | 100% coverage;<br>not subject to deductible                                  | 70% coverage;<br>subject to deductible                                    |
| <b>Primary Care Physician or Specialist Office - Treatment of illness or injury</b>   | 100% coverage<br>after a \$25 PCP or \$50 SPC copay per visit         | NO COVERAGE    | 100% coverage<br>after a \$25 PCP or \$50 SPC copay per visit                | NO COVERAGE    | 90% coverage;<br>subject to deductible                                       | 70% coverage;<br>subject to deductible                                    |
| <b>Maternity Care</b><br>(prenatal, delivery and postpartum)  | 100% coverage;<br>after a \$90 copay per pregnancy                    | NO COVERAGE    | 100% coverage;<br>after a \$90 copay per pregnancy                           | NO COVERAGE    | 90% coverage;<br>subject to deductible                                       | 70% coverage;<br>subject to deductible                                    |
| <b>Physician Services Furnished in a Hospital</b><br>Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist. | 100% coverage;<br>subject to deductible                               | NO COVERAGE    | 100% coverage;<br>subject to deductible                                      | NO COVERAGE    | 90% coverage;<br>subject to deductible                                       | 70% coverage;<br>subject to deductible                                    |
| <b>Physician Services for Emergency Room Care</b>   | 100% coverage;<br>subject to deductible                               | NO COVERAGE    | 100% coverage;<br>subject to deductible                                      | NO COVERAGE    | 90% coverage;<br>subject to deductible                                       | 90% coverage;<br>subject to deductible                                    |
| <b>Outpatient Surgery/ Services</b><br>When billed as office visits   | 100% coverage;<br>after a \$25 PCP or \$50 SPC copay per visit        | NO COVERAGE    | 100% coverage;<br>after a \$25 PCP or \$50 SPC copay per visit               | NO COVERAGE    | 90% coverage;<br>subject to deductible                                       | 70% coverage;<br>subject to deductible                                    |
| <b>Outpatient Surgery/ Services</b><br>When billed as outpatient surgery at a facility  | 100% coverage;<br>subject to deductible                               | NO COVERAGE    | 100% coverage;<br>subject to deductible                                      | NO COVERAGE    | 90% coverage;<br>subject to deductible                                       | 70% coverage;<br>subject to deductible                                    |
| <b>HOSPITAL SERVICES</b>  |   |                |  |                |  |   |
| <b>Inpatient Services</b><br>Inpatient care, delivery and inpatient short-term acute rehabilitation services  | 100% coverage;<br>after a \$100 copay per day max \$300 per admission | NO COVERAGE    | 100% coverage;<br>after a \$100 copay per day max \$300 per admission        | NO COVERAGE    | 90% coverage;<br>subject to deductible                                       | 70% coverage;<br>subject to deductible + \$50 copay per day (days 1 - 50) |
| <b>Outpatient Surgery/ Services</b><br>Hospital / Facility  | 100% coverage;<br>after a \$100 facility copay per visit              | NO COVERAGE    | 100% coverage;<br>after a \$100 facility copay per visit                     | NO COVERAGE    | 90% coverage;<br>subject to deductible                                       | 70% coverage;<br>subject to deductible                                    |

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|--|---|----------------|---|----------------|--|--|
| NETWORK  | Louisiana Blue<br>Community Blue & Blue Connect Providers   |                | Louisiana Blue<br>Preferred Care Provider &<br>Blue Cross National Providers                                |                | Louisiana Blue<br>Preferred Care Provider &<br>Blue Cross National Providers   |  |
| COVERED SERVICES   | IN-NETWORK  | OUT-OF-NETWORK | IN-NETWORK  | OUT-OF-NETWORK | IN-NETWORK   | OUT-OF-NETWORK   |
| <b>HOSPITAL SERVICES</b>   |   |                |   |                |  |  |
| <b>Emergency Room - Hospital (Facility)</b><br>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 |
| <b>BEHAVIORAL HEALTH</b>   |   |                |   |                |  |  |
| <b>Mental Health and Substance Abuse</b><br>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)             |
| <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    | 90% coverage; subject to deductible  | 70% coverage; subject to deductible  |
| <b>OTHER COVERAGE</b>  |   |                |   |                |  |  |
| <b>Outpatient Acute Short-Term Rehabilitation Services</b><br>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  |
| <b>Chiropractic Care</b>   | 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  |
| <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    | 90% coverage; subject to deductible  | 70% coverage; subject to deductible  |
| <b>Home Health Care Services</b>   | 100% coverage subject to deductible   | NO COVERAGE    | 100% coverage subject to deductible   | NO COVERAGE    | 90% coverage; subject to deductible  | 70% coverage; subject to deductible  |
| <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    | 90% coverage; subject to deductible  | 70% coverage; subject to deductible  |
| <b>Hospice Care</b>  | 100% coverage subject to deductible   | NO COVERAGE    | 100% coverage subject to deductible   | NO COVERAGE    | 80% coverage; subject to deductible  | 70% coverage; subject to deductible  |
| <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    | 90% coverage; subject to deductible  | 70% coverage; subject to deductible  |

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|--|---|----------------|--|----------------|--|--|
| NETWORK  | Louisiana Blue<br>Community Blue & Blue Connect Providers |                | Louisiana Blue<br>Preferred Care Provider &<br>Blue Cross National Providers |                | Louisiana Blue<br>Preferred Care Provider &<br>Blue Cross National Providers |  |
| COVERED SERVICES   | IN-NETWORK  | OUT-OF-NETWORK | IN-NETWORK   | OUT-OF-NETWORK | IN-NETWORK   | OUT-OF-NETWORK                         |
| <b>OTHER COVERAGE</b>  |   |                |  |                |  |  |
| <b>Hearing Aid</b><br>Not covered for individuals age eighteen (18) and older                              | 80% coverage;<br>subject to deductible                    | NO COVERAGE    | 80% coverage;<br>subject to deductible                                       | NO COVERAGE    | 90% coverage;<br>subject to deductible                                       | 70% coverage;<br>subject to deductible |
| <b>Transplant Services</b>   | 100% coverage;<br>subject to deductible                   | NO COVERAGE    | 100% coverage;<br>subject to deductible                                      | NO COVERAGE    | 90% coverage;<br>subject to deductible                                       | 70% coverage;<br>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).

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