



2026 Summary of Benefits

Lagniappe Advantage (PPO I-SNP)

H6566, Plan 001

This is a summary of drug and health services covered by Lagniappe Advantage (PPO I-SNP) from January 1 – December 31, 2026.

Lagniappe Advantage (PPO I-SNP) is a Medicare Advantage Local PPO plan with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

This information is not a complete description of benefits. Call 1-844-217-0052, TTY should call 711, for more information.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, visit our website at LagniappeAdvantage.com, or call Member Services and request the *Evidence of Coverage*.

To reach our Member Services Representatives:

- Toll-free number: 1-844-217-0052, TTY/TDD should call 711.
- Hours of operation: 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

To join Lagniappe Advantage (PPO I-SNP), you must:

- Have both Medicare Part A and Medicare Part B,
- -- *and* -- live in our geographic service area,
- -- *and* -- be a United States citizen or be lawfully present in the United States,
- -- *and* -- meet the special eligibility requirements: Our plan is designed to meet the specialized needs of people who need a level of care that is usually provided in a nursing home. To be eligible for our plan, you must reside in one of our participating nursing facilities for greater than 90 days. The plan's *Provider Directory* has a list of participating nursing facilities. You can access this list on our website at LagniappeAdvantage.com or call Member Services and ask us to send you a list.

Our service area includes these parishes in Louisiana: Bossier, Caddo, Calcasieu, East Baton Rouge, Livingston, Rapides, and St. Tammany.

Lagniappe Advantage (PPO I-SNP) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at LagniappeAdvantage.com. Our plan also allows you to see providers outside of our network (non-contracted providers). Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

This document is also available in braille and in large print.

If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2026* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Medical Benefits

Benefit category	Your plan benefits
Monthly plan premium <i>(includes both medical and drug coverage)</i>	\$32.90 You must continue to pay your Medicare Part B premium.
Deductible	You pay the 2026 Original Medicare cost-sharing amounts. The Part A deductible is \$1,736. The Part B deductible is \$283.
Maximum out-of-pocket amount <i>(does not include Part D prescription drugs)</i>	In-Network: \$9,250 This is the most you will pay out-of-pocket each year for Medicare-covered services received from network providers. In- and Out-of-Network Combined: \$13,900 This is the most you will pay out-of-pocket each year for Medicare-covered services received from any provider.

Benefit category	Your plan benefits
<p>Inpatient hospital coverage</p>	<p>In-Network: You pay the 2026 Original Medicare cost-sharing amounts.</p> <p>You pay a \$1,736 deductible for each Medicare-covered stay \$0 copayment per day for days 1-60 \$434 copayment per day for days 61-90 \$868 copayment per day for each lifetime reserve day (up to 60 days over your lifetime)</p> <p><i>Prior authorization is required.</i></p> <p>Out-of-Network: You pay the 2026 Original Medicare cost-sharing amounts.</p> <p>You pay a \$1,736 deductible for each Medicare-covered stay \$0 copayment per day for days 1-60 \$434 copayment per day for days 61-90 \$868 copayment per day for each lifetime reserve day (up to 60 days over your lifetime)</p>

Benefit category	Your plan benefits
<p>Diagnostic services/labs/imaging</p> <p>Diagnostic tests and procedures</p> <p>Diagnostic radiology services (e.g., MRI, CAT scan)</p> <p>Lab services</p> <p>Outpatient x-rays</p> <p>Therapeutic radiology</p>	<p>In-Network: 20% coinsurance <i>Prior authorization is required.</i></p> <p>Out-of-Network: 20% coinsurance</p> <p>In-Network: 20% coinsurance <i>Prior authorization is required.</i></p> <p>Out-of-Network: 20% coinsurance</p> <p>In-Network: \$0 copayment <i>Prior authorization is required.</i></p> <p>Out-of-Network: \$0 copayment</p> <p>In-Network: 20% coinsurance <i>Prior authorization is required.</i></p> <p>Out-of-Network: 20% coinsurance</p> <p>In-Network: 20% coinsurance <i>Prior authorization is required.</i></p> <p>Out-of-Network: 20% coinsurance</p>

Benefit category	Your plan benefits
<p>Hearing services (Medicare-covered)</p> <p>Medicare-covered services</p> <p>Hearing services (Supplemental)</p> <p>Routine hearing exam</p> <p>Fitting/evaluation(s) for hearing aids</p> <p>Hearing aids</p>	<p>In-Network: 20% coinsurance</p> <p>Out-of-Network: 20% coinsurance</p> <p>In-Network: \$0 copayment Limit 1 visit every year</p> <p>Out-of-Network: \$0 copayment Limit 1 visit every year</p> <p>In-Network: \$0 copayment Unlimited visits</p> <p>Out-of-Network: \$0 copayment Unlimited visits</p> <p>In-Network: \$1,500 every year for both ears combined</p> <p>Out-of-Network: \$1,500 every year for both ears combined</p> <p>Benefit is administered by NationsBenefits</p>

Benefit category	Your plan benefits
<p>Dental services (Medicare-covered)</p> <p>Medicare-covered services</p>	<p>In-Network: 20% coinsurance</p> <p><i>Prior authorization is required.</i></p> <p>Out-of-Network: 20% coinsurance</p>
<p>Dental services (Supplemental)</p> <p>Preventive and comprehensive services</p>	<p>In-Network: \$0 copayment for oral exam(s) (limit 2 every year), cleaning(s) (limit 2 every year), and Fluoride treatment(s) (limit 1 every 6 months). See <i>Evidence of Coverage</i> for Dental x-rays limitations.</p> <p>Maximum: \$2,000 every year for preventive services and comprehensive services</p> <p>All services must be provided by Liberty Dental. To locate a network provider, you may call Member Services, or search the Liberty Dental provider directory online at libertydentalplan.com/lagniappeadvantage.</p> <p>Out-of-Network: \$0 copayment for oral exam(s) (limit 2 every year), cleaning(s) (limit 2 every year), and Fluoride treatment(s) (limit 1 every 6 months). See <i>Evidence of Coverage</i> for Dental x-rays limitations.</p> <p>Maximum: \$2,000 every year for preventive services and comprehensive services</p>

Benefit category	Your plan benefits
<p>Vision services (Medicare-covered)</p> <p>Exam to diagnose and treat diseases and conditions of the eye</p> <p>For people with diabetes, screening for diabetic retinopathy is covered once per year</p> <p>Eyewear after cataract surgery</p> <p>Glaucoma screening</p>	<p>In-Network: 20% coinsurance</p> <p>Out-of-Network: 20% coinsurance</p> <p>In-Network: 20% coinsurance</p> <p>Out-of-Network: 20% coinsurance</p> <p>In-Network: 20% coinsurance</p> <p>Out-of-Network: 20% coinsurance</p> <p>In-Network: \$0 copayment</p> <p>Out-of-Network: \$0 copayment</p>

Benefit category	Your plan benefits
<p>Skilled Nursing Facility (SNF)</p>	<p>In-Network: You pay the 2026 Original Medicare cost-sharing amounts.</p> <p>\$0 copayment per day for days 1-20 \$217 copayment per day for days 21-100</p> <p><i>Prior authorization is required.</i></p> <p>Out-of-Network: You pay the 2026 Original Medicare cost-sharing amounts.</p> <p>\$0 copayment per day for days 1-20 \$217 copayment per day for days 21-100</p>
<p>Physical therapy</p>	<p>In-Network: 20% coinsurance</p> <p><i>Prior authorization is required.</i></p> <p>Out-of-Network: 20% coinsurance</p>

Outpatient Prescription Drugs

Prescription drug payment stages	Your plan benefits		
Prescription drug deductible	\$615 Deductible applies.		
Initial coverage	You stay in the Initial Coverage stage until your total out-of-pocket costs reach \$2,100. You then move on to the Catastrophic Coverage Stage.		
Drug coverage	Standard retail cost sharing (in-network) (up to a 30-day supply)	Mail-order cost sharing (up to a 90-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)
Drug coverage	25% coinsurance	Not covered	25% coinsurance
Catastrophic coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$2,100, you pay nothing for your covered Part D prescription drugs.		

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

Important Message About What You Pay for Insulin - You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Additional Benefits

Benefit category	Your plan benefits
Diabetic monitoring supplies	<p>In-Network: 20% coinsurance</p> <p>Out-of-Network: 20% coinsurance</p>
Dialysis services	<p>In-Network: 20% coinsurance</p> <p>Out-of-Network: 20% coinsurance</p>
Durable Medical Equipment (DME)	<p>In-Network: 20% coinsurance</p> <p><i>Prior authorization is required.</i></p> <p>Out-of-Network: 20% coinsurance</p>
Healthy Living Flex Card <ul style="list-style-type: none"> • Over-The-Counter (OTC) items 	<p>In-Network: \$150 every 3 months to spend towards OTC Items. Funds roll over each period until the end of the year.</p> <p>Out-of-Network: \$150 every 3 months to spend towards OTC Items. Funds roll over each period until the end of the year.</p> <p>Benefit is administered by The Helper Bees</p>

