



Healthy Mississippi Institutional (PPO I-SNP)

Summary of Benefits

January 1, 2027 – December 31, 2027

To be a member of our plan, you must be entitled to Medicare Part A, have Medicare Part B, and reside in our service area. In addition, to enroll in this plan you must, for 90 days or longer, have needed (or be expected to need) the level of care provided in a long-term care facility, such as a skilled nursing facility, or receive an equivalent level of care while living in the community. The Service area for Healthy Mississippi Institutional (PPO I-SNP) includes the following counties: Adams, Alcorn, Amite, Attala, Benton, Bolivar, Calhoun, Carroll, Chickasaw, Choctaw, Claiborne, Clarke, Clay, Coahoma, Copiah, Covington, DeSoto, Forrest, Franklin, George, Greene, Grenada, Hancock, Harrison, Hinds, Holmes, Humphreys, Issaquena, Itawamba, Jackson, Jasper, Jefferson, Jefferson Davis, Jones, Kemper, Lafayette, Lamar, Lauderdale, Lawrence, Leake, Leflore, Lincoln, Lowndes, Madison, Marion, Marshall, Monroe, Montgomery, Neshoba, Newton, Noxubee, Oktibbeha, Panola, Pearl River, Perry, Pike, Pontotoc, Prentiss, Quitman, Rankin, Scott, Sharkey, Simpson, Smith, Stone, Sunflower, Tallahatchie, Tate, Tippah, Tishomingo, Tunica, Union, Walthall, Warren, Washington, Wayne, Webster, Wilkinson, Winston, Yalobusha, and Yazoo.

We're here to help

You may have questions as you read through this document, and that's OK. We are here to help. Please call us at 833-201-6413 (TTY users dial 711), 8:00 am – 8:00 pm CST 7 days a week from October 1 to March 31, and Monday through Friday from April 1 to September 30.

Comparing Coverage

If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits. Or you can use the Medicare Plan Finder on www.medicare.gov.

More about Original Medicare

If you want to know more about the coverage and costs of Original Medicare, look in your current Medicare handbook.

View the handbook online at:

www.medicare.gov/medicare-and-you

Get a copy of the handbook 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

About the Plan

Which doctors, hospitals, and pharmacies can I use?

The Healthy Mississippi Institutional (PPO I-SNP) Plan has a network of doctors, hospitals, and other providers. As a PPO plan, you can use providers who are in our network (in-network) or providers who are not in our network (out-of-network). For all Medicare-covered services, you have out-of-network coverage, usually at a higher cost share. Please refer to your Evidence of Coverage (EOC) for more detailed information.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

What do we cover?

- We cover all benefits covered by Original Medicare
- We also cover some benefits that Original Medicare does not cover. Some of these benefits are highlighted in this Summary of Benefits. For a complete list, please refer to your EOC.

- You can see the plan's Drug List, which is also called a formulary, which lists the Part D prescription drugs we cover, along with any restrictions on our website at www.healthy-ms.com
- You can also call us for a copy of the Drug List.

This benefit information is a brief summary of your benefits. It does not list every benefit, or every exclusion. To get a complete list, please refer to the EOC on our website at www.healthy-ms.com. You may also call us and ask us to mail you a copy of the EOC.

Benefits - Medical		
	In-network	Out-of-network
Monthly Plan premium	\$0 per month You must continue to pay your Medicare Part B premium.	
Medical deductible	\$900 annual deductible. The deductible applies only to certain Medicare-covered services. Please refer to your EOC for the list of services the deductible applies to.	
Maximum Out-of-pocket responsibility (MOOP)	\$9,250. This is the most you will pay for in-network Medicare covered services ¹ Combined in-network and out-of-network: \$9,250 ¹ ¹ The MOOP does not apply to non-Medicare covered services.	

Benefits - Medical		
	In-network	Out-of-network
Inpatient hospital – Acute [‡]	You pay the standard Medicare cost-sharing amounts. For 2026 these are: \$1,736 deductible per benefit period \$0 copayment per day, days 1-60 \$434 copayment per day, days 61-90 \$868 copayment per day, days 91 and beyond (lifetime reserve days). The cost-sharing amount shown is based on the 2026 standard Medicare cost share. CMS has not yet released the 2027 Standard Medicare cost share. We will let you know the new amounts once the 2027 Medicare cost-sharing amounts become available.	You pay the standard Medicare cost-sharing amounts. For 2026 these are: \$1,736 deductible per benefit period; \$0 copayment per day, days 1-60 \$434 copayment per day, days 61-90 \$868 copayment per day, days 91 and beyond (lifetime reserve days). The cost-sharing amount shown is based on the 2026 standard Medicare cost share. CMS has not yet released the 2027 Standard Medicare cost share. We will let you know the new amounts once the 2027 Medicare cost-sharing amounts become available.

Benefits - Medical		
	In-network	Out-of-network
Inpatient hospital – Mental health [‡]	You pay the standard Medicare cost-sharing amounts. For 2026 these are: \$1,736 deductible per benefit period \$0 copayment per day, days 1-60 \$434 copayment per day, days 61-90 \$868 copayment per day, days 91 and beyond (lifetime reserve days). The cost-sharing amount shown is based on the 2026 standard Medicare cost share. CMS has not yet released the 2027 Standard Medicare cost share. We will let you know the new amounts once the 2027 Medicare cost-sharing amounts become available.	You pay the standard Medicare cost-sharing amounts. For 2026 these are: \$1,736 deductible per benefit period \$0 copayment per day, days 1-60 \$434 copayment per day, days 61-90 \$868 copayment per day, days 91 and beyond (lifetime reserve days). The cost-sharing amount shown is based on the 2026 standard Medicare cost share. CMS has not yet released the 2027 Standard Medicare cost share. We will let you know the new amounts once the 2027 Medicare cost-sharing amounts become available.
Outpatient observation [‡]	20% coinsurance	30% coinsurance
Outpatient hospital (surgery) [‡]	0% coinsurance for diagnostic colonoscopy; 20% coinsurance for all other surgeries	30% coinsurance
Ambulatory surgical center (ASC) [‡]	0% coinsurance for diagnostic colonoscopy; 20% coinsurance for all other surgeries	30% coinsurance
Primary care (PCP)	\$0 copayment per visit	30% coinsurance

Benefits - Medical		
	In-network	Out-of-network
Specialist visit	0% coinsurance if the service takes place within your Institutional Facility, 20% if the service takes place outside of your institutional facility.	30% coinsurance
Preventive care (annual wellness visit, breast cancer screening, certain vaccines)	\$0 copayment for all Medicare-covered preventive services	
Emergency care	20% coinsurance, up to a \$115 maximum per visit. Coinsurance is waived if admitted within 24 hours	
Urgently needed services	20% coinsurance, up to a \$40 maximum per visit	20% coinsurance, up to a \$40 maximum per visit
Diagnostic services [‡] : Diagnostic tests and procedures [‡] Lab services [‡] Diagnostic radiology (CT, MRI) [‡] Therapeutic radiology (radiation) [‡] X-ray services [‡]	Diagnostic procedures and tests[‡]: 20% coinsurance Labs[‡]: \$0 copayment per visit Diagnostic radiology (CT, MRI)[‡]: 20% coinsurance Therapeutic Radiology (Radiation)[‡]: 20% coinsurance X-rays[‡]: 20% coinsurance	Diagnostic procedures and tests[‡]: 30% coinsurance Labs[‡]: \$0 copayment per visit Diagnostic radiology (CT, MRI)[‡]: 30% coinsurance Therapeutic Radiology (Radiation)[‡]: 30% coinsurance X-rays[‡]: 30% coinsurance

Benefits - Medical		
	In-network	Out-of-network
Hearing services: Medicare covered hearing services Non-Medicare covered hearing services: Routine hearing exam Hearing aid fitting/evaluation Prescription hearing aids	Medicare covered hearing services: \$0 copayment Non-Medicare covered hearing services: Routine hearing exams: \$0 copayment for one exam per year Hearing aid fitting/evaluation: \$0 copayment for one fitting/evaluation per year Prescription hearing aids: \$0 copayment \$1,950 hearing aid allowance, both ears combined, per year. Limited to two aids per year. The allowance is shared between in-network and out-of-network use.	Medicare covered hearing services: 30% coinsurance Non-Medicare covered hearing services: 50% coinsurance \$1,950 hearing aid allowance, both ears combined, per year. Limited to two aids per year. This allowance is combined for in-network and out-of-network services. You can submit for reimbursement up to the allowance amount, less any applicable coinsurance. Once the annual maximum is reached, you are responsible for all costs

Benefits - Medical		
	In-network	Out-of-network
Dental services: Medicare covered dental services Non-Medicare covered dental services: Routine dental visits Preventive services: Services include routine exams, x-rays, cleanings and fluoride treatment. Comprehensive services: Services include restorative services, Endodontics, Periodontics, Prosthodontics: removable and fixed, Maxillofacial Prosthetics, Oral and Maxillofacial Surgery, and Adjunctive General Services. Please note Implants and Orthodontics are not covered.	Medicare covered Dental services: 20% coinsurance Non-Medicare covered dental services: \$3,000 annual allowance for diagnostic, preventive, and comprehensive dental care. The allowance is shared between in-network and out-of-network use. \$0 copayment for covered preventive dental services including: routine exams, x-rays, cleanings, and fluoride treatment until the annual maximum is met. Two visits per year for routine exams and cleanings, one visit per year for x-rays and fluoride treatment. \$0 copayment for covered comprehensive dental services until the annual maximum is met. Once the annual maximum is reached, you are responsible for all costs	Medicare covered Dental services: 30% coinsurance Non-Medicare covered dental services: 50% coinsurance \$3,000 annual allowance for diagnostic, preventive, and comprehensive dental care. This allowance is combined for in-network and out-of-network services. You can submit for reimbursement up to the allowance amount, less any applicable coinsurance. Once the annual maximum is reached, you are responsible for all costs

Benefits - Medical		
	In-network	Out-of-network
Vision services: Medicare covered vision services	Medicare covered Glaucoma screening or diabetic retinal exam: 20% coinsurance Medicare covered eye exam: 20% coinsurance Medicare covered eyewear: \$0 copayment for Medicare covered standard frames and lenses after cataract surgery	Medicare covered Glaucoma screening or diabetic retinal exam: 30% coinsurance Medicare covered eye exam: 30% coinsurance Medicare covered eyewear: 30% coinsurance
Non-Medicare covered vision services	Non-Medicare covered vision services: Routine Vision: \$0 copayment for one routine eye exam per year \$325 combined maximum plan allowance for contacts, eyeglasses (lenses and frames), eyeglass lenses, eyeglass frames, and upgrades. Eyeglasses (lenses and frames) are limited to one per year; all other categories are unlimited. The allowance is shared between in-network and out-of-network use.	Non-Medicare covered vision services: 50% coinsurance \$325 combined maximum plan allowance for contacts, eyeglasses (lenses and frames), eyeglass lenses, eyeglass frames, and upgrades. Eyeglasses (lenses and frames) are limited to one per year; all other categories are unlimited. The allowance is shared between in-network and out-of-network use. You can submit for reimbursement up to the allowance amount, less any applicable coinsurance.

Benefits - Medical		
	In-network	Out-of-network
Outpatient mental health	Psychiatrist and Mental health specialty outpatient services²: 0% coinsurance if the service takes place within your Institutional Facility, 20% if the service takes place outside of your institutional facility. <i>² Includes individual and group therapy sessions</i>	Psychiatrist and Mental health specialty outpatient services²: 30% coinsurance <i>² Includes individual and group therapy sessions</i>
Skilled nursing facility (SNF) [‡]	\$0 copayment per day, days 1-100	30% coinsurance
Diabetic supplies and services [‡] Diabetic therapeutic shoes and inserts [‡] Diabetic monitors [‡] : (Continuous Glucose Monitors (CGMs) and Blood Glucose Monitors (BGMs))	Diabetic supplies and services[‡]: 0% coinsurance Diabetic therapeutic shoes and inserts[‡]: 0% coinsurance Diabetic monitors (CGMs and BGMs)[‡]: 20% coinsurance	Diabetic supplies and services[‡]: 30% coinsurance Diabetic therapeutic shoes and inserts[‡]: 30% coinsurance Diabetic monitors (CGMs and BGMs)[‡]: 30% coinsurance
Ambulance services – Ground (non-emergent) [‡]	20% coinsurance	20% coinsurance
Ambulance services – Air [‡]	20% coinsurance	20% coinsurance

Benefits - Medical		
	In-network	Out-of-network
Medicare Part B drugs [‡]	Medicare Part B drugs (including chemotherapy/radiation drugs, and other Part B drugs) [‡] : 0% to 20% coinsurance Part B insulin [‡] : 0% to 20% coinsurance, up to a \$35 maximum per one-month supply	Medicare Part B drugs (including chemotherapy/radiation drugs, and other Part B drugs) [‡] : 30% coinsurance Part B insulin [‡] : 30% coinsurance
Outpatient rehabilitation including physical therapy, occupational therapy, and speech language therapy (PT, OT, ST) [‡]	Physical therapy (PT), Speech therapy (ST), and Occupational therapy (OT) [‡] : 0% coinsurance if the service takes place within your Institutional Facility, 20% if the service takes place outside of your institutional facility.	Physical therapy (PT), Speech therapy (ST), and Occupational therapy (OT) [‡] : 30% coinsurance

Benefits - Medical		
	In-network	Out-of-network
Over-the-counter (OTC)	\$300 combined quarterly allowance All members receive this allowance for over-the-counter (OTC) items. It is a shared allowance with SSBCI (Special Supplemental Benefits for the Chronically Ill); members who qualify for SSBCI may also use the same allowance for eligible SSBCI benefits. Please see the SSBCI row in this chart for more details. If a member qualifies, this allowance may be used for both benefits. Unused amounts roll over to the next quarter until the end of the plan year.	50% coinsurance (applies to OTC only; * SSBCI has no out-of-network coverage) You can submit for reimbursement up to the allowance amount, less any applicable coinsurance. This allowance is combined for in-network and out-of-network services.
Fitness	\$50 monthly allowance Unused amounts do not roll over to the next month. This allowance is combined for in-network and out-of-network services.	50% coinsurance You can submit for reimbursement up to the allowance amount, less any applicable coinsurance.

Benefits - Medical		
	In-network	Out-of-network
Bathroom safety devices	\$150 maximum allowance per year Unused amounts do not roll over to the next year. This allowance is combined for in-network and out-of-network services.	50% coinsurance \$200 maximum allowance per year You can submit for reimbursement up to the allowance amount, less any applicable coinsurance. This allowance is combined for in-network and out-of-network services.

Special Supplemental Benefits

If you are diagnosed with one or more of the chronic conditions listed within our EOC and meet the eligibility criteria, you may be eligible for additional benefits under our plan. Enrollment in our plan does not guarantee eligibility.

	In-network	Out-of-network
SSBCI – Special Supplemental Benefits for the Chronically Ill[†] The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify. The top five eligible chronic conditions include: Cardiovascular Disease, Chronic Kidney Disease, Diabetes, Chronic lung disorders, and Overweight, Obesity, and Metabolic Disorder. There are other chronic conditions eligible for this benefit. Please see your EOC for detailed information. To be eligible, members must have one or more qualifying chronic conditions, be at high risk of hospitalization or other adverse health outcomes and require intensive care coordination.	\$300 combined quarterly allowance This is the same shared allowance described in the Over-the-counter (OTC) row. If you qualify, you may use this allowance for your SSBCI benefits, your OTC benefit, or both. SSBCI benefits include: - Groceries (food and produce) - General supports for living (utilities, rent, and mortgage assistance) - Unused amounts roll over to the next quarter until the end of the plan year. There is no out-of-network coverage for SSBCI benefits. [†]Member must qualify to receive this benefit. Please refer to your <i>Evidence of Coverage</i> for more detailed information.	Not covered

[†]Services marked with a double dagger (†), may require prior authorization and is the responsibility of your provider

Prescription drug benefits

Deductible	If you receive Extra Help, you have a \$0 deductible. If you do not receive Extra Help, you have a \$700 deductible for Tier 3, Tier 4, and Tier 5 drugs.		
Initial coverage	In this stage, you pay the following until your yearly out-of-pocket costs reach \$2,400. You won't pay more than 25% coinsurance or \$35, whichever is less, for a one-month (30-day) supply of insulin. You won't pay more than 25% coinsurance or \$105, whichever is less, for a 100-day supply of insulin.		
	Tier	30 day supply	100 day supply
	Tier 1 - Preferred Generic	\$0 copayment	\$0 copayment
	Tier 2 - Generic	\$0 copayment	\$0 copayment
	Tier 3 - Preferred Brand	25% coinsurance	25% coinsurance
	Tier 4 - Non-preferred Drug	25% coinsurance	25% coinsurance
	Tier 5 - Specialty	25% coinsurance	Tier 5 is only covered up to a 30-day supply
Catastrophic coverage	After your yearly out-of-pocket costs reach \$2,400, the plan pays the full costs of your Part D drugs, and you pay nothing.		

Healthy Mississippi Institutional (PPO I-SNP) is a PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal and service area. Our plans are not available in all counties.

Benefits, features, and/or devices vary by plan/service area. Limitations, exclusions, and restrictions may apply. Contact the plan for more information. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

This information is not a complete description of benefits. Please see the EOC for a complete description of benefits, exclusions, limitations, and conditions of coverage.

The formulary, pharmacy network, and/or provider network can change at any time. You will receive notice when necessary.

Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Healthy Mississippi, Inc.'s pharmacy network includes limited lower-cost, preferred pharmacies in our service area, including in suburban and rural counties across Mississippi. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 833-201-6413, and TTY 711 or consult the online pharmacy directory at www.healthy-ms.com.

Out-of-network/non-contracted providers are under no obligation to treat Healthy Mississippi, Inc. members, except in emergency situations. Please call our Member Services number or see your EOC for more information.