SimpraAdvantage
Alabama's Healthplan

Summary of Benefits

2024 Simpra Advantage (PPO D-SNP)
H4091, Plan 002

This is a summary of drug and health services covered by Simpra Advantage (PPO D-SNP) January 1, 2024 - December 31, 2024.

Simpra Advantage (PPO D-SNP) is a Medicare Advantage PPO plan (PPO stands for Preferred Provider Organization) with a Medicare contract. Enrollment in the plan depends on contract renewal.

This information is not a complete description of benefits. Call 1-844-637-4770, TTY/TDD users should call 1-833-312-0044, 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 Simpra.com, or call Member Services and request the *Evidence of Coverage* (EOC).

To Reach Our Member Services Representatives:

- Toll Free 1-844-637-4770, TTY/TDD should call 1-833-312-0044.
- 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 Simpra Advantage (PPO D-SNP), you must:

- be entitled to Medicare Part A,
- -- *and* -- be enrolled in Medicare Part B,
- -- *and* -- live in our service area,
- -- *and* -- receive any type of assistance from the Title XIX (Medicaid) program, including full benefit dual eligible individuals, as well as those eligible only for the Medicare Savings Programs (QMB-only, QMB-plus, SQMB-plus).

Our service area includes these counties in Alabama: Autauga, Baldwin, Barbour, Bibb, Blount, Bullock, Butler, Calhoun, Chambers, Cherokee, Chilton, Choctaw, Clarke, Clay, Cleburne, Coffee, Colbert, Conecuh, Coosa, Covington, Crenshaw, Cullman, Dale, Dallas, DeKalb, Elmore, Escambia, Etowah, Fayette, Franklin, Geneva, Greene, Hale, Henry, Houston, Jackson, Jefferson, Lamar, Lauderdale, Lawrence, Lee, Limestone, Lowndes, Macon, Madison, Marengo, Marion, Marshall, Mobile, Monroe, Montgomery, Morgan, Perry, Pickens, Pike, Randolph, Russell, Shelby, St. Clair, Sumter, Talladega, Tallapoosa, Tuscaloosa, Walker, Washington, Wilcox, and Winston.

Simpra Advantage (PPO D-SNP) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at Simpra.com. If you use providers that are not in our network, the plan may not pay for these services.

This document is also available in alternative formats, such as large print or audio.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You 2023" handbook. View it online at https://www.medicare.gov or get 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.

Simpra Advantage (PPO D-SNP)	
Monthly Plan Premium *(includes both medical and drugs)*	$41.40 You must continue to pay your Medicare Part B premium.
Deductible	Original Medicare Part B deductible is $240 Original Medicare Part A deductible is $1,632 Total deductible is $1,872
Maximum Out-of-Pocket Amount (does not include Part D prescription drugs)	From network providers: $8,850 From network and out-of-network providers combined: $13,300

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Ambulance Services Ground and air ambulance	**In-Network and Out-of-Network** 20% coinsurance for each one-way Medicare-covered ground or air ambulance service. *Pre-authorization is not required for Medicare-covered non-emergent transport.*
Ambulatory Surgical Center (ASC)	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. *Prior authorization is required.*
Dental Services	
Medicare-covered dental	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. *Prior authorization is required.*
Supplemental Benefits: Preventive and/or comprehensive services	**In-Network and Out-of-Network** $0 copayment
Routine oral exam, dental cleaning, fluoride treatment and x-rays annually	**Preventive:** 2 Oral Exams every year; 2 Prophylaxis (Cleanings) every year; 1 Fluoride treatment; and 1 Dental X-Rays every year; **Comprehensive:** Restorative Services; Endodontics; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services; Up to $2,400 allowance towards preventive and/or comprehensive dental services combined every benefit year.

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Diagnostic Services/Labs/Imaging	
Diagnostic tests and procedures	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. *Prior authorization may be required.*
Diagnostic radiology services (e.g., MRI, CAT Scan)	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. *Prior authorization may be required for limited services (e.g., PET Scans).* *CT scans and MRI do not require authorization.*
Lab services	**In-Network** $0 copayment for each Medicare-covered service. *Prior authorization required for Genetic Testing.* **Out-of-Network** 20% coinsurance for each Medicare-covered service. *Prior authorization required for Genetic Testing.*
Outpatient X-rays	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service.
Therapeutic Radiology	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. *Prior authorization is required for the initial course of treatment.*
Doctor Visits	
Primary Care Providers	**In-Network and Out-of-Network** $0 copayment
Specialists	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service.
Emergency Care	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. Up to a maximum of $90 per visit. Coinsurance is waived if you are admitted to a hospital within 3 days of your emergency care visit. Coverage is limited to the United States and its territories.

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Hearing Services Hearing exam *Supplemental Benefits:*	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service.
• Annual routine hearing exam	**In-Network and Out-of-Network** $0 copayment for each Medicare-covered service. Limited to 1 hearing exam visit(s) every year
• Annual Hearing-aid Fitting/Evaluation	**In-Network and Out-of-Network** $0 copayment for each Medicare-covered service. Limited to 1 hearing-aid fitting/evaluation visit(s) every year
• Coverage every two years includes over-the-counter hearing-aids	**In-Network and Out-of-Network** $0 copayment Hearing-aid(s) coverage up to $1,600 every two years for both ears combined. You pay nothing up to $1,600 allowance.
Inpatient Hospital coverage	**In-Network and Out-of-Network** You pay the 2024 Original Medicare cost-sharing amounts. $1,632 deductible. Day 1 – 60: $0 copayment for each Medicare-covered day Day 61 – 90: $408 copayment each day for each Medicare-covered day Day 91 -150: $816 copayment for each Medicare-covered day (lifetime reserve days) Medicare hospital benefit periods apply. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. *Prior authorization is required for elective hospitalization.*

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Medicare Part B Prescription Drugs	
Chemotherapy/Radiation Drugs	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. *For chemotherapy, authorization is required for the initial drug approval only*.
Other Part B drugs	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. *Prior authorization may be required for certain medications.* Certain Part B drugs may be subject to step therapy. Those drugs are included in categories such as Ophthalmic Disorders and Viscosupplement. **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.
Mental Health Services Inpatient visit	**In-Network and Out-of-Network** You pay the 2024 Original Medicare cost-sharing amounts $1,632 deductible Day 1 – 60: $0 copayment each Medicare-covered day Day 61 – 90: $408 copayment each Medicare-covered day Day 91 – 150: $816 copayment each Medicare-covered day (lifetime reserve days) *Prior authorization is required.*
Outpatient Hospital coverage Outpatient hospital services	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. *Prior authorization may be required for some services.*
Outpatient hospital observation services	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service.

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Outpatient Mental Health Care includes partial-hospitalization, individual and group therapy visits.	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service.
Physical Therapy	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. *Prior authorization may be required.*
Preventive Care *(e.g., flu, COVID-19, pneumonia, and Hepatitis B vaccines, diabetes, and other screening tests)*	**In-Network and Out-of-Network** You pay nothing for each Medicare-covered service. **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.
Skilled Nursing Facility (SNF) Care	**In-Network and Out-of-Network** You pay the 2024 Original Medicare cost-sharing amounts. Day 1 – 20: $0 copayment each day for each Medicare-covered skilled nursing facility stay. Day 21 – 100: $204 copayment each day for each Medicare-covered skilled nursing facility stay. *Prior authorization is required.*
Transportation (Routine)	**In-Network and Out-of-Network** Not covered
Urgently Needed Services	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service Up to a maximum of $55 per visit Coinsurance is waived if you are admitted to a hospital within 3 days of your urgently needed services. Coverage is limited to the United States and its territories.

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Vision Care	**In-Network and Out-of-Network**
Exam to diagnose and treat diseases and conditions of the eye	20% coinsurance for each Medicare-covered service.
For people with diabetes, screening for diabetic retinopathy is covered once per year.	20% coinsurance for each Medicare-covered service.
Eyewear after cataract surgery	**In-Network** $0 copayment for each Medicare-covered service.
Glaucoma screening	**Out-of-Network** 20% coinsurance for each Medicare-covered service.
Supplemental Vision Benefits include:	
• One routine vision exam annually	**In-Network and Out-of-Network**
• Glasses and contacts covered up to $300 total each benefit year. This allowance does not apply to eyewear obtained following cataract surgery.	20% coinsurance for each Medicare-covered service. $0 copayment/coinsurance Limited to 1 routine exam visit(s) every year

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Outpatient Prescription Drug Benefits and Cost-Sharing	
Deductible	$545 for all Part D prescription drugs.
Initial Coverage Phase	During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription. 25% coinsurance **Standard retail cost-sharing** (in-network) (up to a 30-day supply) 25% coinsurance **Standard mail-order cost-sharing** (up to a 90-day supply) 25% coinsurance **Long-term care (LTC) cost-sharing** (up to a 31-day supply)
Coverage Gap	After your total drug costs (including what our plan has paid and what you have paid) reach $5,030, you will pay no more than 25% coinsurance for generic drugs and for brand name drugs. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing
Catastrophic Coverage	Once your out-of-pocket costs have reached 8,000 you leave the Coverage Gap Stage and move into the Catastrophic Coverage Stage. You will stay in this payment stage until the end of the calendar year.

Cost-sharing may differ based on point-of-service (mail-order, retail, Long Term Care (LTC)), home infusion, whether the pharmacy is in our standard network, or whether the prescription is a short-term (30-day supply) or long term (90-day supply).

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.

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Additional Benefits	
Annual Physical Exam	**In-Network and Out-of-Network** $0 copayment *No authorization required.*
Diabetic monitoring supplies	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service *Prior authorization is required.*
Diabetic therapeutic shoes or inserts	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. *Prior authorization is required.*
Memory Fitness Benefit Annual subscription to BrainHQ, an online memory fitness program.	**In-Network** $0 copayment
Occupational Therapy	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service *Prior authorization may be required.*
Over-the-Counter Benefit The OTC Catalog benefit offered through CVS, provides you with a quarterly allowance that you can spend during the benefit year on certain over-the-counter medications, as well as health and wellness products such as common cold medicines, vitamins, healthy foods and more. You must use the CVS OTC program for this benefit.	**In-Network** $0 copayment $150 allowance every quarter (three months) for eligible OTC items. Unused credits roll over to the next quarter of the benefit year; however, will not be carried over more than one quarter during the benefit year. Credits do not carry over to the following benefit year. **Out-of-Network** Not covered.
Podiatry Services (Foot Care) Foot exams and treatment	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service.

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Additional Benefits

Social Companion Benefit Additional support for members with certain chronic conditions and needing additional non-clinical attention. Qualifying conditions include: • *Alzheimer's Disease, intellectual disabilities, and related conditions* • *Anxiety disorders, bipolar disorder, depression, paranoid disorder, schizophrenia* • *Asthma, Chronic bronchitis, Emphysema, COPD* • *Peripheral vascular disease, ischemic heart disease* • *Malnutrition including failure to thrive*	**In-Network** $0 copayment Up to 25 visits to be determined by the RN Personal Care Coordinator (RN PCC) **Out-of-Network** Not covered.