Simpra Advantage
Alabama's Healthplan

Summary of Benefits

2024 Simpra Advantage (PPO I-SNP)
H4091, Plan 001

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

Simpra Advantage (PPO I-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 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 to review the Evidence of Coverage (EOC), or call Member Services and request a hardcopy of the 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 I-SNP), you must:

- be entitled to Medicare Part A,
- -- *and* -- be enrolled in Medicare Part B,
- -- *and* -- live in our service area,
- -- *and* -- reside in one of our participating nursing facilities for greater than 90 days (or reasonably expect to live in the nursing facility 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 (Simpra.com) or call Member Services (phone number and hours of operation are noted above) and ask us to send you a list.

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 I-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, upon request.

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You 2024"** 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/TDD users should call 1-877-486-2048.

Simpra Advantage (PPO I-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.

Simpra Advantage
Alabama's Healthplan

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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. *Prior authorization is not required for Medicare-covered non- emergent transports.*
Ambulatory Surgical Center (ASC)	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. *Prior authorization is required.*
Dental services	**In-Network and Out of Network** 20% coinsurance for each Medicare-covered service. *Prior authorization is required.*
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, CT 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 MRIs do not require authorization.*
Lab services	**In-Network** $0 copayment for each Medicare-covered service. *Prior authorization is required for Genetic Testing.* **Out-of-Network** 20% coinsurance for each Medicare-covered service. *Prior authorization is required for Genetic Testing.*

SimpraAdvantage
Alabama's Healthplan

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Doctor Visits	
Primary Care Providers	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. ***There is no coinsurance, copayment, or deductible for the Annual Wellness Visit.***
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. Only covered within the United States and its territories.
Hearing services	
Hearing exam	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service.
Supplemental benefit:	
Annual routine hearing exam	**In-Network and Out-of-Network** $0 copayment Limited to 1 visit(s) every year
Annual Hearing Aid Fitting/ Evaluation	**In-Network and Out-of-Network** $0 copayment Limited to 1 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 the $1,600 allowance.

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Inpatient Hospital coverage	**In-Network and Out-of-Network** You pay the 2024 Original Medicare cost-sharing amounts. $1,632 deductible. **In-Network and Out-of-Network (continued)** Days 1 – 60: $0 copayment each Medicare-covered day; Days 61 – 90: $408 copayment each Medicare-covered day; Days 91 – 150: $816 copayment 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.*
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.* *You never pay more than $35 for a one-month supply of each insulin product covered by our plan, even if you haven't paid your deductible.*

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Mental Health Services Inpatient visit	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered visit. Cost shares are applied starting on the first day of admission and do not include the day of discharge. *Prior authorization is required.*
Outpatient Mental Health Care: Services includes partial-hospitalization, individual and group therapy visits	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered visit.
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.
Physical Therapy and Speech-Language Pathology Services	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service.
Preventive Care (e.g., flu, COVID-19, pneumonia, and Hepatitis B vaccines, diabetes self-management training, and other screening tests)	**In-Network and Out-of-Network** You pay nothing for each Medicare-covered preventive 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** Days 1 – 20: $0 copayment for each Medicare- covered day. Days 21 – 100: $204 copayment for each Medicare- covered day. Days 101 and beyond: You pay all costs. *Prior authorization is required.*
Transportation (Routine)	**In-Network and Out-of-Network** Not covered

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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 urgent care visit. Limited to the United States and its territories.
Vision Care	
Exam to diagnose and treat diseases and conditions of the eye	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service.
For people with diabetes, screening for diabetic retinopathy is covered once per year	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service.
Eyewear after cataract surgery	**In-Network** $0 copayment for each Medicare-covered service. **Out-of-Network** 20% coinsurance for each Medicare-covered service.
Glaucoma screening	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service.
Supplemental Vision Benefits:	
Routine eye exam	**In-Network and Out-of-Network** $0 copayment Limited to 1 visit every year
Eyeglasses (lenses and frames) and/or contact lenses	**In-Network and Out-of-Network** $0 copayment Glasses/Contacts coverage up to $230 total combined credit every year. *(This allowance does not apply to eyewear obtained following cataract surgery)*

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.
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. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. 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).

Simpra Advantage
Alabama's Healthplan

Additional Benefits	
Diabetic monitoring supplies	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service
Diabetic therapeutic shoes or inserts	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service.
Occupational therapy	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service.
Supplemental Benefit: **Over-the-counter (OTC) 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 $50 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. **Out-of-Network** Not covered.
Podiatry services (Foot care) Foot exams and treatment **Supplemental Benefit:** **Additional routine foot care**	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered podiatry service. **In-Network and Out-of-Network** $0 copayment for each routine foot care service. Limited to 6 routine foot care visit(s) every year.
Supplemental Benefit: **Social Companion Benefit** Provides additional support for members with certain chronic conditions and needing additional non-clinical attention. Qualifying conditions include: • Alzheimer's Disease • Anxiety Disorder • Bipolar Disorder • Dementia • Intellectual Disability	**In-Network** $0 copayment/coinsurance for each Medicare-covered service. Covers up to 55 hours to be determined by the RN Care Coordinator (RNCC). The number of hours provided will be dependent upon the length of time needed and the benefit limit to be determined by the RN Care Coordinator. **Out-of-Network** Not covered.