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Summary of Benefits

2025 Simpra Advantage Assist Plan
H4091-003 PPO I-SNP

This is a summary of drug and health services covered by Simpra Advantage Assist (PPO I-SNP)
January 1, 2025 - December 31, 2025

Simpra Advantage Assist (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.

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. For a complete list of benefits, see Chapter 4 of your *Evidence of Coverage* (EOC) online: https://simpra.com/for-members/plan-documents. To request a hard copy of the EOC, please call Member Services at the number below.

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. local time, seven days a week from October 1 through March 31, and Monday to Friday from April 1 through September 30. Member Services is closed on the following Holidays: Memorial Day, Independence Day, Labor Day, Thanksgiving, and Christmas.

To join Simpra Advantage Assist (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 Assist (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"** handbook. View it online at www.medicare.gov/medicare-and-you 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.users should call 1-877-486-2048.

Simpra Advantage Assist (PPO I-SNP)	
Monthly Plan Premium *(includes both medical and drugs)*	$86.00 You must continue to pay your Medicare Part B premium.
Deductibles	No deductible for Medicare Part A and Part B medical services. See Prescription Drug Coverage for Part D deductible.
Maximum out-of-Pocket (MOOP) (does not include Part D prescription drugs)	**In-network providers:** $6,700 **In-network and Out-of-network providers combined**: $10,000

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Inpatient Hospital Services	**In-Network and Out-of-Network** $1,676 deductible. Days 1 to 6: $175 copayment only. Days 7 to 90: $0 copayment each day for Medicare-covered hospital care. Days 91 – 150 (lifetime reserve days): $0 copayment for each day. 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 all non-emergency admissions.*
Outpatient Hospital Services	**In-Network and Out-of-Network** $50 copayment for each Medicare-covered Outpatient Hospital Service or Surgery *Prior authorization may be required for some services.*
Outpatient Hospital Observation Services	**In-Network and Out-of-Network** $100 copayment for each Medicare-covered Observation visit.
Ambulatory Surgical Center (ASC)	**In-Network and Out-of-Network** $50 copayment for each Medicare-covered outpatient surgery service. *Prior authorization is required.*
Doctor Visits • Primary Care Providers	**Primary Care: In-Network and Out-of-Network** You pay $0 for Medicare-covered primary care visit There is no coinsurance, copayment, or deductible for the annual wellness visit.
• Specialty Care Providers	**Specialists: In-Network and Out-of-Network** You pay $30 for Medicare-covered specialist services per visit. *Prior authorization may be required for certain services.*

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	Telehealth – In-Network No cost-sharing for Primary Care Physicians, Kidney Disease Education Services, and Diabetes Self-Management Training. $30 copayment for Medicare-covered Physician Specialist services, and Individual and Group Psychiatric Services. 20% coinsurance for Dialysis and all other Telehealth. **Telehealth – Out-of-Network** Not covered.
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.
Emergency Care	**In-Network and Out-of-Network** $90 copayment for each Medicare-covered service visit. • Coinsurance is waived if you are admitted to a hospital within 3 days of your emergency care visit. • Covered in the United States and its territories.
Urgently Needed Services	**In-Network and Out-of-Network** $30 copayment for each Medicare-covered visit. • Coinsurance is waived if you are admitted to a hospital within 3 days of your urgent care visit. • Covered in the United States and its territories.
Diagnostic Services/Labs/Imaging • Outpatient X-rays • Diagnostic and therapeutic radiology services	**In-Network and Out-of-Network** $5 copayment for each Medicare-covered general x-ray service **In-Network and Out-of-Network** $50 copayment per visit for each Medicare-covered diagnostic and therapeutic radiological service *Prior authorization may be required.*

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• Diagnostic tests and procedures	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. *Prior authorization may be required for certain diagnostic tests and procedures (e.g., PET Scans).* *CT scans and MRI do not require authorization.*
• Blood Services	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered blood service.
• Lab services	**In-Network and Out-of-Network** $0 copayment for each Medicare-covered lab service. *Prior authorization is required for Genetic Testing.*
Hearing services Hearing exam	**In-Network and Out-of-Network** $10 copayment for each Medicare-covered service.
Supplemental Hearing Benefits: • Annual routine hearing exam • Annual Hearing Aid Fitting/ Evaluation	**In-Network and Out-of-Network** $0 copayment Limited to 1 routine visit every year **In-Network and Out-of-Network** $0 copayment Limited to 1 hearing-aid evaluation/fitting visit every year
• Hearing-aid Allowance	**In-Network and Out-of-Network** $0 copayment You pay nothing up to the $2,000 allowance for hearing-aid(s) coverage every two years for both ears combined. Over-the-counter hearing-aids are included in coverage.
Dental services Limited Medicare-covered dental services (e.g., jaw reconstruction following fracture or injury, tooth extractions in preparation for cancer treatment involving jaw, and oral exams prior to kidney transplantation)	**In-Network and Out of Network** 20% coinsurance for each Medicare-covered dental service. *Prior authorization is required for Medicare-covered comprehensive dental services.*

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Supplemental Dental Services: Two (2) routine oral exams and dental cleanings, fluoride treatment, and 1 set of x-rays annually	**In-Network and Out of Network** $0 copayment / 0% coinsurance You pay nothing up to $750 allowance for preventive/comprehensive dental services combined annually
Vision Care • Exam to diagnose and treat diseases and conditions of the eye • For people with diabetes, screening for diabetic retinopathy • Eyewear after cataract surgery • Glaucoma screening	**In-Network and Out-of-Network** $30 copayment for each Medicare-covered service.
Supplemental Vision Benefits: • Routine eye exam • Eyeglasses (lenses and frames) and/or contact lenses	**In-Network and Out-of-Network** $0 copayment/coinsurance for one routine vision exam visit annually. You pay nothing up to $230 allowance for glasses (lenses and frames) and contacts each benefit year. *(This allowance does not apply to eyewear obtained following cataract surgery.)*
Mental Health Services (Inpatient)	**In-Network and Out-of-Network** Days 1 – 6: $175 copayment each Medicare-covered visit. Days 7 – 90: $0 copayment each Medicare-covered visit. Days 91 – 150 (lifetime reserve days : $0 copayment for each day Medicare hospital benefit periods apply. Cost shares are applied starting on the first day of admission and do not include the day of discharge. *Prior authorization is required.*
Mental Health Services (Outpatient)	**In-Network and Out-of-Network (Outpatient)** $30 copayment for each Medicare-covered service. Coverage includes partial hospitalization, individual and group therapy visits, and intensive outpatient services.
Skilled Nursing Facility (SNF) Care	**In-Network and Out-of-Network** No copayment/coinsurance for Medicare-covered SNF admission. No prior hospital stay is required. *Prior authorization may be required.*

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Physical Therapy Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs)	**In-Network and Out-of-Network** $0 copayment for each Medicare-covered physical therapy and speech-language pathology service. $30 copayment for each Medicare-covered CORF service. *Prior authorization may be required.*
Ambulance services Ground and Air Ambulance	**In-Network** $150 copayment for each one-way Medicare-covered ground ambulance service. 20% coinsurance for each one-way Medicare-covered air ambulance service. **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.*
Transportation (Routine)	**In-Network and Out-of-Network** Not covered.
Medicare Part B Prescription Drugs • Chemotherapy/Radiation drugs	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered chemotherapy and radiation drug 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 other Medicare-covered Part B drugs. *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 pay 20% coinsurance up to no 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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Outpatient Prescription Drug Benefits and Cost-Sharing			
Deductible	$150 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.		
Tier	**Standard retail cost-sharing** (Up to a 30-day supply)	**Standard mail-order cost-sharing** (Up to a 90-day supply)	**Long-term care (LTC) cost-sharing** (Up to a 31-day supply)
Tier 1 Preferred Generic	$4 copayment	$12 copayment	$4 copayment
Tier 2 Generic	$15 copayment	$45 copayment	$15 copayment
Tier 3 Preferred Brand	$45 copayment	$135 copayment	$45 copayment
Tier 4 Non-Preferred Brand	$95 copayment	$285 copayment	$95 copayment
Tier 5 Specialty	31% coinsurance	31% coinsurance	31% coinsurance
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).		
Catastrophic Coverage	Once your out-of-pocket costs have reached $2,000 you move into the Catastrophic Coverage Stage. During this phase, the plan pays the full cost for your covered Part D drugs. 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.

Important Message About Certain Drugs – Due to the Inflation Reduction Act of 2022, there may be some Medicare Part B drugs covered by our plan that will have a coinsurance lower than 20%. If you purchase one of these Part B drugs, you will be eligible for a refund for any overpayment made at the point of service.

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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 NationsBenefits®, provides you with a quarterly allowance that you can spend during the benefit year on certain health and wellness products. You must use Simpra's OTC program for this benefit. For details on approved items and retailers please visit Simpra.NationsBenefits.com.	**In-Network** $0 copayment $235 allowance every quarter (three months) for eligible OTC items. Unused credits roll over to the next quarter of the benefit year; however, they 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** 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 25 visits 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.

Simpra Advantage Assist is a PPO I-SNP with a Medicare contract. Enrollment in Simpra Advantage depends on contract renewal. Simpra Advantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

The Benefits Mastercard® Prepaid Card is issued by The Bancorp Bank N.A., Member FDIC, pursuant to license by Mastercard International Incorporated and card can be used for eligible expenses wherever Mastercard is accepted. Valid only in the U.S. No cash access. This is not a gift card or gift certificate. Prepaid card is distributed as a gratuity without the payment of any monetary value or consideration. This card cannot be used to pay for prescription drugs or products that are not eligible. Product exclusions include alcohol, tobacco, firearms and gift cards. If you would like to buy items that are not eligible, you will need to use another form of payment.

SSBCI benefits are Special Supplemental Benefits for the Chronically Ill. To be eligible for these benefits (Social Needs benefit, Food and Produce benefit), the member must have one or more of the following chronic conditions: Cardiovascular disorders, Dementia, Diabetes, Chronic lung disorders, Stroke, or certain other eligible conditions not listed here. If you qualify for one of the chronic conditions, you must also qualify as a "chronically ill" enrollee as defined by CMS regulations and on this Plan's coverage criteria for SSBCI.