SimpraAdvantage
Alabama's Healthplan

# 2026 Summary of Benefits

| 2026 Assist PPO I-SNP | | |
|---|---|---|
| Monthly Plan Premium<br>*(includes both medical and drugs)* | $81.00<br>You must continue to pay your Medicare Part B premium. | |
| Deductibles | No deductible for Medicare Part A and Part B medical services.<br>*See Prescription Drug Coverage for Part D deductible.* | |
| Maximum Out-of-Pocket (MOOP) amount<br>*(does not include Part D prescription drugs)* | $6,700 In-Network / $10,000 In- and Out-of-Network combined | |
| **Benefits** | **In-Network** | **Out-of-Network** |
| Inpatient Hospital Coverage | Days 1 to 6: $175 copayment only<br>Days 7 to 90: $0 copayment each day for Medicare-covered hospital care<br>Days 91 to 150 (lifetime reserve days): $0 copayment for each day<br>*Prior authorization is required.* | |
| Outpatient Hospital Services | $50 copayment for each Medicare-covered Outpatient Hospital Service or Surgery<br>*Prior authorization is required.* | |
| Outpatient Observation Services | $100 copayment for each Medicare-covered Observation visit | |
| Ambulatory Surgical Center (ASC) | $50 copayment for each Medicare-covered outpatient surgery service<br>*Prior authorization is required* | |
| Primary Care Provider Visit | You pay $0 for Medicare-covered primary care per visit | |
| Primary Care Provider Telehealth Visit | $0 Copayment | Not covered |
| Specialty Care Provider Visit | You pay $30 for Medicare-covered specialist services per visit<br>*Prior authorization is required.* | |
| Specialty Care Provider Telehealth Visit | $30 Copayment | Not covered |
| Preventive Care Services<br>including Annual Wellness Visit | You pay nothing for each Medicare-covered preventive service<br>**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<br>(Coverage limited to U.S. and its territories only) | $90 copayment for each Medicare-covered visit | |
| Urgent Care<br>(Coverage limited to U.S. and its territories only) | You pay $30 for Medicare-covered specialist services per visit | |
| Diagnostic Services: Outpatient X-rays | $5 copayment for each Medicare-covered general x-ray service<br>*Prior authorization is required.* | |

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| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Diagnostic Services: Diagnostic and therapeutic radiology services | $50 copayment per visit for each Medicare-covered diagnostic and therapeutic radiological service<br>*Prior authorization is required.* | |
| Diagnostic Services: Diagnostic tests and procedures | 20% coinsurance for each Medicare-covered service<br>*Prior authorization is required for certain diagnostic tests and procedures (e.g., PET Scans). CT scans and MRI do not require authorization.* | |
| Diagnostic Services: Blood Services | 20% coinsurance for each Medicare-covered blood service | |
| Diagnostic Services: Lab Services | $0 copayment for each Medicare-covered lab service<br>*Prior authorization is required for Genetic Testing.* | |
| Hearing Exam | $10 copayment for each Medicare-covered service | |
| Supplemental Hearing Benefits:<br>Annual Routine Hearing Exam | $0 copayment<br>Limited to 1 routine visit every year | |
| Supplemental Hearing Benefits:<br>Annual Hearing Aid Fitting/Evaluation | $0 copayment<br>Limited to 1 hearing aid evaluation/fitting visit every year | |
| Supplemental Hearing Benefits:<br>Hearing Aid Allowance | $0 Copayment<br>You pay nothing up to the $2,000 allowance for hearing aid(s) coverage every two years for both ears combined.<br>Non-prescription hearing aids are included in coverage. | |
| Dental Services | 20% coinsurance for each Medicare-covered dental service<br>*Prior authorization is required for Medicare-covered comprehensive dental services.*<br>*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)* | |
| Supplemental Dental Services: | $0 copayment / 0% coinsurance<br>You pay nothing up to $750 allowance for preventive/ comprehensive dental services combined annually. | |
| Vision Care | $30 copayment for each Medicare-covered service | |
| Supplemental Vision Benefit:<br>Routine Eye Exam including refraction | $0 copayment/coinsurance for one routine vision exam annually | |
| Supplemental Vision Benefit:<br>Eyeglasses (lenses and frames) and/or contact lenses | $230 total allowance for glasses (lenses and frames) and contact lenses each benefit year.<br>*This allowance does not apply to eyewear obtained following cataract surgery.* | |

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| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Mental Health Services – Inpatient | Days 1 – 6: $175 copayment each Medicare-covered day<br>Days 7 – 90: $0 copayment each Medicare-covered day<br>Days 91 – 150 (lifetime reserve days): $0 copayment for each day<br>*Prior authorization is required.* | |
| Mental Health Services – Outpatient | $30 copayment for each Medicare-covered service | |

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 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.

## Outpatient Prescription Drug Benefits—Cost Sharing (Part D)

| | | | |
|---|---|---|---|
| **Deductible** | $150 for all Part D prescription drugs. | | |
| **Initial Coverage Stage** | 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 |
| *The Coverage Gap Stage was removed in 2025. The Part D prescription drug "donut hole" no longer exists.* | | | |
| Catastrophic Coverage Stage | Once your out-of-pocket costs have reached $2,100 you move into the Catastrophic Coverage Stage. During this stage, 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. | | |

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| Additional Benefits | In-Network | Out-of-Network |
|---|---|---|
| Ambulance Services: Ground Ambulance | $150 copayment for each one-way Medicare-covered ground ambulance service | 20% coinsurance for each one-way Medicare-covered ground ambulance service |
| Ambulance Services: Air Ambulance | 20% coinsurance for each one-way Medicare-covered air ambulance service | |
| Diabetic Monitoring Supplies | 20% coinsurance for each Medicare-covered service | |
| Diabetic Therapeutic Shoes or Inserts | 20% coinsurance for each Medicare-covered service | |
| Medicare Part B Prescription Drugs:<br>Chemotherapy/Radiation Drugs<br>Other Part B drugs | 0%-20% coinsurance for each Medicare-covered chemotherapy/ radiation drug service and other Medicare-covered Part B drugs<br>*Prior authorization is required for certain medications.*<br>***Important Message About What You Pay for Insulin:*** *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.* | |
| Occupational Therapy Services | $0 copayment/0% coinsurance for each Medicare-covered service<br>*Prior Authorization is required for certain providers.* | |
| Physical Therapy Services | $0 copayment for each Medicare-covered physical therapy service.<br>$30 copayment for each Medicare-covered CORF service.<br>*Prior authorization is required for certain providers.* | |
| Speech-Language Pathology Services | $0 copayment for each Medicare-covered speech-language pathology service.<br>$30 copayment for each Medicare-covered CORF service.<br>*Prior authorization is required for certain providers.* | |
| Podiatry Services (Foot Care):<br>Foot exams and treatment | 20% coinsurance for each Medicare-covered podiatry service | |
| Supplemental Benefit:<br>Additional routine foot care | $0 copayment for each routine foot care service;<br>limited to 6 routine foot care visit(s) every year | |
| Skilled Nursing Facility (SNF) Care | No copayment/coinsurance for Medicare-covered SNF admission. No prior hospital stay is required.<br>*Prior authorization is required.* | |
| Supplemental Benefit:<br>Over-the-Counter benefit | $0 Copayment and you receive a $235 quarterly allowance on the Simpra Benefits Mastercard® Prepaid Card to spend on health and wellness products from in-network retailers. Unused allowance will not carry over to the next quarter. For details on approved items and retailers please visit Simpra.NationsBenefits.com.<br>***In-Network coverage only*** | |

| Additional Benefits | In-Network | Out-of-Network |
|---|---|---|
| Special Supplemental Benefit for the Chronically Ill (SSBCI): Food & Produce and OTC combined allowance | Your $235 quarterly OTC allowance benefit noted above may also be used toward food and produce. Unused allowance will not carry over to the next quarter. For details on approved items and retailers please visit Simpra.NationsBenefits.com.<br>*Member must have one or more qualifying chronic conditions. Please see qualifying conditions at the end of this document.*<br>***In-Network coverage only*** | |
| Supplemental Benefit: Social Companion Benefit | $0 copayment/coinsurance for each Medicare-covered service. Covers up to 25 visits, to be determined by the RN Care Coordinator.<br>*Member must have one or more qualifying chronic conditions. Please see qualifying conditions at the end of this document.*<br>***In-Network coverage only.*** | |
| Transportation (Routine) | Not covered. | |
| Telehealth | No cost-sharing for Primary Care Physicians, Kidney Disease Education Services, and Diabetes Self-Management Training<br>$30 copayment for Medicare-covered Physician Specialist services, and Individual and Group Psychiatric Services<br>20% coinsurance for Dialysis and all other Telehealth | |

## About Simpra Advantage

### Summary of Benefits:

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. This document is also available in alternative formats, such as large print or audio, upon request. For a complete list of benefits, see Chapter 4 of the *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.

If you want to know more about the coverage and costs of Original Medicare, look in your 2026 **"Medicare & You"** handbook. Visit http://www.medicare.gov/medicare-and-you to view or download a copy. You may also request 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.

### Special Supplemental Benefits for the Chronically Ill (SSBCI):

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, Chronic lung disorders, Dementia, Diabetes mellitus, Stroke, or certain other eligible conditions not listed here. Not all enrollees qualify. If you qualify for one of the chronic conditions, your coverage also depends on being a "chronically ill enrollee" as defined by CMS regulations and on this Plan's coverage criteria for SSBCI.

### Provider Network:

Simpra Advantage serves all counties in Alabama. For information on the Simpra Advantage network of doctors, hospitals, pharmacies, and other providers, visit our website at Simpra.com. If you use providers that are not in our network, the Plan may not pay for these services. 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.

## 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
- you live at home or an institutional setting, and our Plan has obtained certification that you need the type of care that is usually provided in a nursing home.

## To reach our Member Services Representatives:

- Toll Free **1-844-637-4770** (for accommodations call TTY/TDD **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, Juneteenth, Independence Day, Labor Day, Thanksgiving, and Christmas.

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Simpra Advantage Assist is a PPO I-SNP with a Medicare contract. Enrollment in Simpra Advantage depends on contract renewal. Based on a Model of Care review, Simpra Advantage has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2027. 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.

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