

2027 Dual Care (PPO D-SNP)

Please note this is only a summary of costs. **Because you are eligible for Medicare cost-sharing assistance under Medicaid, you may pay as low as \$0 for your deductible, doctor office visits, and inpatient hospital stays. That means, you pay a \$0 Copayment if the provider accepts Medicaid, or if not, you pay the Medicare amount for 2027.** Please read your *Evidence of Coverage* online (<https://simpra.com/for-members/plan-documents>) for complete benefit information.

Monthly Plan Premium	\$0 Medical Premium / \$13.70 Drug Premium (\$0 with Extra Help) Your Part B Premium may be covered by Medicaid.
Deductibles	\$0 Medical deductible and \$700 Drug deductible (\$0 with Extra Help)
Maximum Out-of-Pocket (MOOP) amount	\$9,850 In-Network / \$14,800 In- and Out-of-Network combined

Benefits	In-Network	Out-of-Network
Inpatient Hospital Coverage	0% Coinsurance <i>Prior authorization required.</i>	\$0 Copayment / 0-20% Coinsurance* <i>Prior authorization required.</i>
Outpatient Hospital Coverage and Services	0% Coinsurance <i>Prior authorization required.</i>	0-20% Coinsurance* <i>Prior authorization required.</i>
Ambulatory Surgical Center (ASC)	0% Coinsurance <i>Prior authorization required.</i>	0-20% Coinsurance* <i>Prior authorization required.</i>
Primary Care Provider Visit	\$0 Copayment	\$0 Copayment / 0% Coinsurance
Primary Care Provider Telehealth Visit	0% Coinsurance	Not Covered
Specialty Care Provider Visit	0% Coinsurance <i>Prior authorization is not required.</i>	0-20% Coinsurance* <i>Prior authorization is not required.</i>
Specialty Care Provider Telehealth Visit	0% Coinsurance	Not Covered
Preventive Care Services including Annual Wellness Visit	\$0 Copayment	\$0 Copayment

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 at 1-844-637-4770 (for accommodations call TTY/TDD 1-833-312-0044).

*\$0 Copayment if the provider accepts Medicaid, or if not, the member pays the Medicare Coinsurance amount for 2027.

Benefits	In-Network	Out-of-Network
Emergency Care (Coverage limited to U.S. and its territories only)	0% Coinsurance	0-20% Coinsurance Maximum \$90 per visit*
Urgent Care (Coverage limited to U.S. and its territories only)	0% Coinsurance	0-20% Coinsurance Maximum \$40 per visit*
Diagnostic Services: Diagnostic and Therapeutic Radiological Services	0% Coinsurance <i>Prior Authorization is required for therapeutic services. Prior authorization is not required for diagnostic services.</i>	0-20% Coinsurance* <i>Prior Authorization is required for therapeutic services. Prior authorization is not required for diagnostic services.</i>
Diagnostic Services: Outpatient X-rays	0% Coinsurance <i>Prior Authorization is not required.</i>	0-20% Coinsurance* <i>Prior Authorization is not required.</i>
Diagnostic Services: Diagnostic tests and procedures	0% Coinsurance <i>Prior Authorization is not required.</i>	0-20% Coinsurance* Prior authorization is not required.
Diagnostic Services: Blood Services	0% Coinsurance	0-20% Coinsurance*
Diagnostic Services: Lab Services	\$0 Copayment <i>Prior Authorization is required for Genetic Testing.</i>	0-20% Coinsurance* <i>Prior Authorization required.</i>
Hearing Exam (Medicare-Covered)	0% Coinsurance	0-20% Coinsurance*
Supplemental Benefit: Hearing Exam (Routine)	\$0 Copayment / 0% Coinsurance One exam each year	\$0 Copayment / 0% Coinsurance One exam each year
Supplemental Benefit: Hearing Aids (includes Annual Fitting/Evaluation)	\$0 Copayment / 0% Coinsurance \$2,200 allowance every two years for both ears combined. Non-prescription hearing aids are covered.	\$0 Copayment / 0% Coinsurance \$2,200 allowance every two years for both ears combined. Non-prescription hearing aids are covered.
Dental Services (Medicare-covered)	0% Coinsurance <i>Prior authorization required.</i>	0-20% Coinsurance* <i>Prior authorization required.</i>
Supplemental Benefit: Preventive and Comprehensive Dental Care <i>2 oral cleanings, 1 routine x-ray, and 1 fluoride treatment each year.</i>	\$0 Copayment / 0% Coinsurance \$2,000 allowance each year.	\$0 Copayment / 20% Coinsurance \$2,000 allowance each year.

*\$0 Copayment if the provider accepts Medicaid, or if not, the member pays the Medicare Coinsurance amount for 2027.

Benefits	In-Network	Out-of-Network
Vision Care (Medicare-covered)	0% Coinsurance	0-20% Coinsurance*
Supplemental Benefit: Routine Eye Exam including refraction	\$0 Copayment / 0% Coinsurance	\$0 Copayment / 0% Coinsurance*
Supplemental Benefit: Eyewear Credit		
1 pair of contact lenses and/or Eyeglasses (lenses and frames) annually	\$0 Copayment / 0% Coinsurance \$400 allowance every year	\$0 Copayment / 0% Coinsurance \$400 allowance every year
This allowance does not apply to eyewear obtained following cataract surgery.		
Mental Health Services: Inpatient Services	0% Coinsurance <i>Prior authorization required.</i>	\$0 Copayment / 0-20% Coinsurance* <i>Prior authorization required.</i>
Mental Health Services: Outpatient Services	0% Coinsurance <i>Prior authorization required.</i>	0-20% Coinsurance* <i>Prior authorization required.</i>
Skilled Nursing Facility	0% Coinsurance <i>Prior authorization required.</i>	\$0 Copayment / 0-20% Coinsurance* <i>Prior authorization required.</i>
Physical Therapy, Occupational Therapy, Speech-Language Pathology Therapy Services	0% Coinsurance <i>Prior authorization required.</i>	0-20% Coinsurance* <i>Prior authorization required.</i>
Ambulance Service (Ground or Air)	0% Coinsurance	0-20% Coinsurance* for each one-way trip
Supplemental Benefit: Transportation Services	\$0 Copayment / 0% Coinsurance Maximum of 48 one-way rideshare trips to plan-approved health-related locations.	\$0 Copayment / 0% Coinsurance Maximum of 48 one-way rideshare trips to plan-approved health-related locations.
Medicare Part B Prescription Drugs: Chemotherapy/Radiation drugs, Other Part B drugs, Part B Insulin	0% Coinsurance <i>Prior authorization required.</i>	0-20% Coinsurance* <i>Prior authorization required.</i>

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 even if you haven't paid your deductible.

*\$0 Copayment if the provider accepts Medicaid, or if not, the member pays the Medicare Coinsurance amount for 2027.

Additional Benefits	In-Network	Out-of-Network
Diabetic monitors and monitoring supplies	0% Coinsurance	0-20% Coinsurance*
Diabetic therapeutic shoes or inserts	0% Coinsurance	0-20% Coinsurance*
Podiatry Services (Medicare-covered)	0% Coinsurance	0-20% Coinsurance*

Additional Benefits	In-Network	Out-of-Network
Supplemental Benefit: Social Companion Services	\$0 Copayment Maximum of 15 visits, determined by the Plan requirements.	\$0 Copayment Maximum of 15 visits, determined by the Plan requirements.
Supplemental Benefit: Over-the-Counter (OTC) Program <i>You must use the NationsBenefits® OTC program for this benefit. Unused allowance will not roll over to the next month.</i> <i>You may also use your allowance to pay rent and utilities or to buy personal hygiene items, essential clothing, food, and produce if you qualify for Special Supplemental Benefits. If you qualify for one of the chronic conditions, your coverage also depends on being a "chronically ill enrollee" as defined by CMS requirements and this Plan's coverage criteria. See the About Simpra Advantage section below to learn if you qualify. For details on approved items and participating stores please visit Simpra.NationsBenefits.com or call NationsBenefits® at 1-844-617-3350 (TTY/TDD 711).</i>	\$0 Copayment \$200 monthly allowance on the Simpra Benefits Mastercard® Prepaid Card for health and wellness items.	\$0 Copayment \$200 monthly allowance on the Simpra Benefits Mastercard® Prepaid Card for health and wellness items.

*\$0 Copayment if the provider accepts Medicaid, or if not, the member pays the Medicare Coinsurance amount for 2027.

Outpatient Prescription Drug Benefits – Cost Sharing (Part D)	
Deductible	\$700 for all Part D prescription drugs (\$0 with Extra Help)
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. 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)
Catastrophic Stage	Once your out-of-pocket costs have reached \$2,400, you leave the Initial Coverage 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 the point of service (e.g., mail order, retail, Long Term Care, home infusion), whether the pharmacy is in our standard network, or whether the prescription is a short-term supply (30 days) or long-term supply (90 days). However, you may qualify for a Low-Income Subsidy (LIS) or Extra Help and your cost-sharing would depend on your level of assistance. If you qualify for Extra Help, you will receive a notification detailing your Copayment level and amounts, and you will not pay the 25% Coinsurance. See the table below.

LIS Level	2027 LIS Generic Copayment	2027 LIS Brand Copayment	LIS Deductible
1	\$5.80	\$14.40	\$0.00
2	\$1.65	\$5.00	\$0.00
3	\$0.00	\$0.00	\$0.00

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 2027 “**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.

Provider Network:

Simpra Advantage serves all counties in Alabama. For information on Simpra 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.

Special Supplemental Benefits for the Chronically Ill:

Special Supplemental Benefits for this plan include Over-the-Counter benefits (rent, utilities, personal hygiene items, essential clothing, food and produce) and the Social Needs Benefit. To qualify for these benefits, you must have one or more of the following chronic conditions: Chronic alcohol use disorder and other substance use disorders (SUDs); Autoimmune disorders; Cancer; Cardiovascular disorders; Chronic heart failure; Dementia; Diabetes mellitus; Overweight, obesity, and metabolic syndrome; Chronic gastrointestinal disease; Chronic kidney disease (CKD); Severe hematologic disorders; HIV/AIDS; Chronic lung disorders; Chronic and disabling mental health conditions; Neurologic disorders; Stroke; Post-organ transplantation; Immunodeficiency and Immunosuppressive disorders; Conditions associated with cognitive impairment; Conditions with functional challenges; Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell; Conditions that require continued therapy services in order for individuals to maintain or retain functioning. Not all enrollees qualify. If you do qualify for one of the chronic conditions above, your coverage also depends on being a “chronically ill enrollee” as defined by CMS regulations and on this Plan’s coverage criteria.

To join Simpra Advantage Dual Care (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, QMB-plus, SLMB-plus, FBDE).

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.

Simpra Advantage Dual Care is a PPO D-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. 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. In addition to your Plan premium, if you have any, you must continue to pay your Medicare Part B premium. Medicaid pays the premium for those who meet the Low-Income Subsidy or qualify for Extra Help. We do not offer every plan available in your area. Currently, our contracted sales agents represent eight organizations which offer 104 products in your area. Please contact Medicare.gov, 1-800-MEDICARE (24 hours a day, 7 days a week, except some federal holidays) to get information on all of your options. Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number (Member Services below) or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services. The Benefits Mastercard® Prepaid Card is issued by The Bancorp Bank N.A., pursuant to license by Mastercard International Incorporated and card can be used for eligible expenses wherever Mastercard is accepted. Mastercard and the circles design is a trademark of Mastercard International Incorporated. Valid only in the U.S. No cash access. This is not a gift card or gift certificate. You have received this card 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. For accommodations for persons with special needs, call Member Services at 1-844-637-4770 (TTY/TDD 1-833-312-0044) 8 a.m. – 8 p.m. local time, 7 days a week from 10/1 to 3/31, and Monday to Friday from 4/1 to 9/30. Member Services is closed Memorial Day, Juneteenth, Independence Day, Labor Day, Thanksgiving, and Christmas.