Simpra Advantage
PARTNERS IN WELLNESS

2023 Summary of Benefits

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, 2023 - December 31, 2023.

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 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 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.

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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.

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 I-SNP)	
Monthly Plan Premium *(includes both medical and drugs)*	$35.20 You must continue to pay your Medicare Part B premium.
Deductible	Original Medicare Part B deductible is $226. Original Medicare Part A deductible is $1,600.
Maximum out-of-pocket amount (does not include Part D prescription drugs)	From network providers: $8,300 From network and out-of-network providers combined: $12,450

Inpatient Hospital coverage	**In-Network and Out-of-Network** You pay the 2023 Original Medicare cost-sharing amounts. These are the 2022 cost-sharing amounts and may change for 2023. The plan will provide updated rates at Simpra.com as soon as Medicare releases them. $1,600 deductible. Days 1 – 60: $0 copayment each Medicare-covered day; Days 61 – 90: $400 copayment each Medicare-covered day; Days 91 – 150: $800 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.*

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. *Prior authorization may be required.*
Ambulatory Surgical Center (ASC)	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. *Prior authorization is required.*
Doctor Visits	
Primary Care Providers	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service.
Specialists	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service**.**
Preventive Care (e.g., flu vaccine, diabetic screenings)	**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.
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.
Urgently needed services	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. Up to a maximum of $60 per visit. Coinsurance is waived if you are admitted to a hospital within 3 days of your urgently needed services.

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 is required. CTs head or abdomen 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.*
Outpatient X-rays	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. *Prior authorization may apply for selected services. X-Rays do not require authorization in nursing facility, physician's office, or hospital.*
Therapeutic Radiology	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. *Prior authorization is required.* *Ultrasounds do not require authorization.*

Hearing services	
Hearing exam	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service.
Supplemental benefit	
Routine hearing exam	**In-Network and Out-of-Network** $0 copayment for each Medicare-covered service. Limited to 1 visit(s) every year
Fitting-evaluation(s) for hearing aids	**In-Network and Out-of-Network** $0 copayment for each Medicare-covered service. Limited to 1 visit(s) every year
Hearing aids	**In-Network and Out-of-Network** $0 copayment Up to a $1,600 credit for both ears combined every two years for hearing aids. Limited to 2 hearing aid(s) every two years
Dental services	
Medicare-covered dental	**In-Network and Out of Network** 20% coinsurance for each Medicare-covered service. *Prior authorization is required.*

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 benefits Routine eye exam	**In-Network and Out-of-Network** $0 copayment Limited to 1 visit(s) every year
Eyeglasses (lenses and frames) and/or contact lenses	**In-Network and Out-of-Network** $0 copayment **Up to a $230 combined credit every year.**
Mental Health Services Inpatient visit	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service.
Outpatient group therapy visit	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service.
Outpatient individual therapy visit	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service.

Skilled nursing facility (SNF) care	**In-Network and Out-of-Network** Days 1 – 20: $0 copayment for each Medicare-covered day. Days 21 – 100: $200 copayment for each Medicare-covered day. Days 101and beyond: You pay all costs. *Prior authorization is required.*
Physical Therapy	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. *Prior authorization may be required.*
Ambulance services Ground Ambulance Air Ambulance	**In-Network and Out of Network** 20% coinsurance for each Medicare-covered Ambulance service. **In-Network and Out of Network** 20% coinsurance for each Medicare-covered Ambulance service. *Prior authorization is not required for Medicare-covered non-emergent transports.*
Transportation (additional routine)	**In-Network and Out-of-Network** Not covered
Medicare Part B prescription drugs Chemotherapy/Radiation drugs Other Part B 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* **In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. *Prior authorization may be required for certain medications*

Outpatient Prescription Drugs			
	Standard retail cost-sharing (in-network) (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)
Deductible	$505 for all Part D prescription drugs.		
Cost-Sharing for Covered Drugs	25% coinsurance	25% coinsurance	25% coinsurance
Coverage Gap	After your total drug costs (including what our plan has paid and what you have paid) reach $4,660, you will pay no more than 25% coinsurance for generic drugs and for brand name drugs.		
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay the greater of: • 5% coinsurance, or • $4.15 copayment for generic (including brand drugs treated as generic) and a $10.35 copayment for all other drugs.		

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

Additional Benefits

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.*
Occupational therapy	**In-Network and Out-of-Network** 20% coinsurance for each Medicare-covered service. *Prior authorization may be required.*
Supplemental Benefit Over-the-counter (OTC) benefit	**In-Network** $0 copayment The Health Catalog benefit will provide members a maximum of $50 per quarter that they may spend on items from a designated Health Catalog provided to members by OTC Health Solutions online and at select CVS locations. Unused credits roll over to the next quarter of the benefit year; and will not be carried over more than one quarter. Please contact the plan for more details. **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 service. **In-Network and Out-of-Network** $0 copayment for each Medicare-covered service. Limited to 6 visit(s) every year
Social Companion Benefit	**In-Network** $0 copayment/coinsurance for each Medicare-covered service. Up to 60 hours to be determined by the RN Care Coordinator (RNCC). **Out-of-Network** Not covered.

Pre-Enrollment Checklist

Simpra Advantage (PPO I-SNP)
Simpra Advantage Premier (PPO I-SNP)
Simpra Advantage (PPO D-SNP)

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-844-637-4770 (TTY 1-833-312-0044).

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit Simpra.com or call 1-844-637-4770 (TTY 1-833-312-0044) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services the provider must agree to treat you. Except in an emergency or urgent situation, non- contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non- ontracted providers.
- ☐ **For D-SNP enrollees only:** This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.
- ☐ **For I-SNP enrollees only:** This plan is an institutional special needs plan (I-SNP). Your ability to enroll will be based on verification that you, for 90 days or longer, have had or are expected to need the level of services provided in a skilled nursing facility, a nursing facility, an intermediate care facility for individuals with intellectual and developmental disabilities, a psychiatric hospital or unit, a rehabilitation hospital or unit, a long-term care hospital, a swing-bed hospital, or a facility approved by CMS that furnishes similar services.

Pre-Enrollment Checklist

Simpra Advantage (PPO I-SNP)
Simpra Advantage Premier (PPO I-SNP)
Simpra Advantage (PPO D-SNP)

Simpra Advantage is a PPO I-SNP and a PPO D-SNP with a Medicare contract. Enrollment in Simpra Advantage depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat Simpra Advantage 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.

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.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-637-4770 (TTY 1-833-312-0044).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-844-637-4770 (TTY 1-833-312-0044) 번으로 전화해 주십시오