



January 1 – December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services and Drug Coverage as a Member of Clever Care Breathe+ (HMO C-SNP)

This document gives the details of your Medicare health and drug coverage from January 1 – December 31, 2026. **This is an important legal document. Keep it in a safe place.**

This document explains your benefits and rights. Use this document to understand:

- Our plan premium and cost sharing
- Our medical and prescription drug benefits
- How to file a complaint if you are not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Member Services at 1-833-388-8168 (TTY users call 711). Hours are October 1st through March 31st 8 am to 8 pm, seven days a week; April 1st through September 30th 8 am to 8 pm, Monday through Friday. This call is free.

This plan, Clever Care Breathe+, is offered by Clever Care Health Plan, Inc.. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Clever Care Health Plan, Inc.. When it says “plan” or “our plan,” it means Clever Care Breathe+.)

This document is available for free in Chinese, Korean, Spanish, and Vietnamese.

It is also available in different formats, including large print, audio, or other alternate formats if you need it. Call Member Services at the number listed above if you need plan information in another format.

Benefits, deductibles, and/or copayments/coinsurance may change on January 1, 2027.

Our formulary, pharmacy network, and/or provider network may change at any time. You will get notice about any changes that may affect you at least 30 days in advance.

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CHAPTER 1:

Get started as a member

SECTION 1 You are a member of Clever Care Breathe+

Section 1.1 You are enrolled in Clever Care Breathe+, which is a specialized Medicare Advantage Plan (Special Needs Plan)

You are covered by Medicare, and you chose to get your Medicare health and drug coverage through Clever Care Breathe+.

Clever Care Breathe+ is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company.

Clever Care Breathe+ is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means its benefits are designed for people with special health care needs. Clever Care Breathe+ is designed to provide additional health benefits that specifically help people who have asthma, chronic bronchitis, emphysema or COPD.

Our plan includes providers who specialize in treating asthma, chronic bronchitis, emphysema or COPD. It also includes health programs designed to serve the specialized needs of people with these conditions. In addition, our plan covers prescription drugs to treat most medical conditions, including drugs usually used to treat asthma, chronic bronchitis, emphysema or COPD. As a member of our plan, you get benefits specially tailored to your condition and have all your care coordinated through our plan.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Clever Care Breathe+ covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (formulary)*, and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called riders or amendments.

The contract is in effect for the months you are enrolled in Clever Care Breathe+ between January 1, 2026, and December 31, 2026.

Medicare allows us to make changes to our plans that we offer each calendar year. This means we can change the costs and benefits of Clever Care Breathe+ after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) must approve Clever Care Breathe+ each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews its approval of our plan.

CHAPTER 1: Get started as a member

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You are eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.2). People who are incarcerated are not considered to be living in the geographic service area, even if they are physically located in it.
- You are a United States citizen or lawfully present in the United States.
- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the specialized needs of people who have certain medical conditions. To be eligible for our plan, you must have a cardiovascular disorder, chronic heart failure, or diabetes.

Note: If you lose your eligibility for our plan but can reasonably be expected to regain eligibility within two month(s), then you are still eligible for membership. Chapter 4, Section 2 tells you about coverage and cost sharing during a period of deemed continued eligibility.

Section 2.2 Plan service area for Clever Care Breathe+

Clever Care Breathe+ is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our service area. The service area is described below.

Our service area includes these counties in California: Los Angeles, Orange, San Bernardino, Riverside, and San Diego.

If you move out of our plan's service area, you cannot stay a member of this plan. Call Member Services at 1-833-388-8168 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

If you move or change your mailing address, it is also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 2.3 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Clever Care Breathe+ if you're not eligible to stay a member of our plan on this basis. Clever Care Breathe+ must disenroll you if you don't meet this requirement.

CHAPTER 1: Get started as a member**SECTION 3 Important membership materials****Section 3.1 Our plan membership card**

Use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if you have one. Sample plan membership card:

		Clever Care Total+ (HMO C-SNP) EFFECTIVE DATE: 01/01/26 PCP EFFECTIVE DATE: 01/01/26	
MEMBER NAME John A. Smith MEMBER ID 000-000-0000 Health Plan (80840)		COPAYMENTS (\$0 if Full Medi-Cal) PCP VISIT: \$0 SPECIALIST VISIT: \$0 URGENT CARE: \$25 ER: \$95	
PCP NAME Brandon Lee MD (555) 555-5555 MEDICAL GROUP/NETWORK Acme Medical Partners		 RxBIN: 004336 RxPCN: MEDDADV RxGRP: RX25AZ H7607 016	
IN AN EMERGENCY CALL 911 OR GO TO THE NEAREST ER			
MEMBER SERVICES (833) 388-8168 (TTY: 711) clevercarehealthplan.com Telehealth: (800) 835-2362 PPO Dental: Liberty Dental (888) 704-9830 Hearing: NationsHearing (866) 304-7577 Vision: (855) 492-9028 Transportation: CareCar (844) 743-4344		HOSPITAL ADMIT AUTH & TRANSFER (888) 888-8888 PRIOR AUTHORIZATION (800) 800-8080 PROFESSIONAL CLAIMS NOBLE AMA IPA 1234 Main St, Suite 100 Small Town, CA 90210 INSTITUTIONAL CLAIMS Prospect Health 456 Elm Dr, Suite 200 Big Town, CA	
PHARMACY HELP DESK & CLAIMS (866) 693-4620 CVS Caremark Medicare Claims Processing P.O. Box 52066, Phoenix, AZ 85072-2066		Printed: 01/01/26	

Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Clever Care Breathe+ membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials).

If our plan membership card is damaged, lost, or stolen, call Member Services at 1-833-388-8168 (TTY users call 711) right away and we will send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* (clevercarehealthplan.com/provider) lists our current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization, you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, situations when it is unreasonable or not possible to get services in-network), out-of-area dialysis services, and cases when Clever Care Breathe+ authorizes use of out-of-network providers.

Get the most recent list of providers and suppliers available on our website at clevercarehealthplan.com/provider.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Member Services at 1-833-388-8168 (TTY users call 711). Requested paper *Provider Directories* will be mailed to you within 3 business days.

CHAPTER 1: Get started as a member**Section 3.3 Pharmacy Directory**

The *Pharmacy Directory* clevercarehealthplan.com/pharmacy lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the *Pharmacy Directory* to find the network pharmacy you want to use. Go to Chapter 5, Section 2.4 for information on when you can use pharmacies that are not in our plan's network.

If you don't have a *Pharmacy Directory*, you can ask for a copy from Member Services at 1-833-388-8168 (TTY users call 711). You can also find this information on our website at clevercarehealthplan.com/pharmacy.

Section 3.4 Drug List (formulary)

Our plan has a *List of Covered Drugs* (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit included in Clever Care Breathe+. The drugs on this list are selected by our plan with the help of doctors and pharmacists. The Drug List must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed and replaced as described in Chapter 5, Section 6. Medicare approved the Clever Care Breathe+ Drug List.

The Drug List also tells if there are any rules that restrict coverage for a drug.

We will give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit clevercarehealthplan.com/druglist or call Member Services at 1-833-388-8168 (TTY users call 711).

SECTION 4 Your monthly costs for Clever Care Breathe+

Cost	2026 (next year)
Monthly plan premium*	\$0
* Your premium can be higher or lower than this amount. Go to Section 4.1 for details.	
Deductible	\$0
	However, this plan has deductibles for some hospital and medical services and Part D prescription drugs.
Maximum out-of-pocket amount	\$9,250
This is the <u>most</u> you will pay out of pocket for covered services.	
(Go to Section 1 for details.)	

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Cost	2026 (next year)
Primary care office visits	\$0 per visit
Specialist office visits	\$0 per visit
Inpatient hospital stays	Deductible: \$1,736 \$0 per day, for days 1-60 and days 91 and more; \$434 per day for days 61-90, per benefit period.
Part D drug coverage deductible (Go to Section 4 for details.)	Deductible: \$615 except for covered insulin products and most adult Part D vaccines.
Part D drug coverage (Go to Chapter 6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment / Coinsurance during the Initial Coverage Stage: • Drug Tier 1: 25% • Drug Tier 2: 25% • Drug Tier 3: 25% You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 4: 25% You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 25% You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 6: \$0 Catastrophic Coverage: During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)

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- Income Related Monthly Adjusted Amount (Section 4.4)
- Medicare Prescription Payment Plan Amount (Section 4.5)

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for Clever Care Breathe+.

If you *already* get help from one of these programs, **the information about premiums in this Evidence of Coverage may not apply to you.** We sent you a separate document, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you do not have this insert, call Member Services at 1-833-388-8168 (TTY users call 711) and ask for the *LIS Rider*.

Section 4.2 Monthly Medicare Part B Premium**Many members are required to pay other Medicare premiums**

You must continue paying your Medicare premiums to stay a member of our plan. This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there was a period of 63 days or more in a row when you did not have Part D or other creditable drug coverage. Creditable drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

When you first enroll in Clever Care Breathe+ we let you know the amount of the penalty. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **do not** have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay your drug costs.
 - You went less than 63 days in a row without creditable coverage.
 - You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or in a newsletter from that plan. Keep this information because you may need it if you join a Medicare drug plan later.
- **Note:** Any letter or notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard drug plan pays.

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- **Note:** Prescription drug discount cards, free clinics, and drug discount websites are not creditable prescription drug coverage.

Medicare determines the amount of the Part D late enrollment penalty. Here is how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, our plan will count the number of full months that you did not have coverage. The penalty is 1% for every month you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty percentage will be 14%.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2026, this average premium amount is \$32.74.
- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium and round it to the nearest 10 cents. In the example here, it would be 14% times \$32.74, which equals \$4.58. This rounds to \$4.60. This amount would be added to **the monthly plan premium for someone with a Part D late enrollment penalty.**

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year** because the national base beneficiary premium can change each year.
- **You will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you are *under* 65 and enrolled in Medicare, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must ask for this review **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you may not have another chance to ask for a review of that late enrollment penalty.

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit <https://www.Medicare.gov/health-drug-plans/part-d/basics/costs>.

If you have to pay an extra IRMAA, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay our plan premium, unless your monthly benefit is not enough to

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cover the extra amount owed. If your benefit check is not enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra IRMAA to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra IRMAA, you will be disenrolled from our plan and lose prescription drug coverage.**

If you disagree about paying an extra IRMAA, you can ask Social Security to review the decision. To find out how to do this, call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 4.5 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you will pay our plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 9 to make a complaint or appeal.

SECTION 5 More information about your monthly plan premium

Section 5.1 How to pay your Part D late enrollment penalty

There are two ways you can pay the penalty.

Option 1: Pay by check

If you chose to pay directly to our plan, you will receive a statement from us. Payments must be received by the last calendar day of the covered month. You may also pay your penalty with a money order or cashier's check. Please attach the payment voucher provided to you along with your monthly bill and write your Clever Care ID number on your check.

Checks should be payable to **Clever Care of Golden State** and mailed to:

Clever Care Health Plan
Attn: Accounting Department
7711 Center Ave Suite 100
Huntington Beach, CA 92647

If your check is a Non-Sufficient Fund (NSF) check, you will be responsible for NSF check related fees.

Option 2: Have Part D late enrollment penalty deducted from your monthly Social Security check.

Changing the way you pay your Part D late enrollment penalty. If you decide to change how you pay your Part D late enrollment penalty, it can take up to 3 months for your new payment method to take effect. While we process your new payment method, you are still responsible

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for making sure your Part D late enrollment penalty is paid on time. To change your payment method, call Member Services.

If you have trouble paying your Part D late enrollment penalty

Your Part D late enrollment penalty is due in our office by the end of the covered month. If we don't get your payment by the end of the covered month, we will send you a notice letting you know our plan membership will end if we do not get your Part D late enrollment penalty within by the last day of the month. If you owe a Part D late enrollment penalty, you must pay the penalty to keep your drug coverage.

If you have trouble paying your Part D late enrollment penalty on time, please contact Member Services at 1-833-388-8168 (TTY users call 711) to see if we can direct you to programs that will help with your costs.

If we end your membership because you did not pay your Part D late enrollment penalty, you will have health coverage under Original Medicare. You may not be able to get Part D drug coverage until the following year if you enroll in a new plan during the Open Enrollment Period. (If you go without creditable drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

If you want to enroll again in our plan (or another plan that we offer) in the future, you will need to pay the amount you owe before you can enroll.

If you think we wrongfully ended your membership, you can make a complaint (also called a grievance). If you had an emergency circumstance out of your control that made you unable to pay your Part D late enrollment penalty within our grace period, you can make a complaint. For complaints, we will review our decision again. Go to Chapter 9 to learn how to make a complaint or call us at 1-833-388-8168 between October 1st through March 31st 8:00 A.M. to 8:00 P.M., seven days a week; April 1st through September 30th 8:00 A.M. to 8:00 P.M., Monday through Friday. TTY users call 711. You must make your complaint no later than 60 calendar days after the date your membership ends.

Section 5.2 Our monthly plan premium won't change during the year

We are not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we will tell you in September and the new premium will take effect on January 1.

However, in some cases, you may be able to stop paying a late enrollment penalty, if you owe one, or you may need to start paying a late enrollment penalty. This could happen if you become eligible for Extra Help or lose your eligibility for Extra Help during the year.

- If you currently pay a Part D late enrollment penalty and become eligible for Extra Help during the year, you would be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the Part D late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

Find out more about Extra Help in Chapter 2, Section 7.

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SECTION 6 Keep our plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage including your Primary Care Physician.

The doctors, hospitals, pharmacists, and other providers in our plan's network **use your membership record to know what services and drugs are covered and your cost-sharing amounts**. Because of this, it is very important you help to keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you are admitted to a nursing home
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you participate in a clinical research study (**Note:** You are not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Member Services at 1-833-388-8168 (TTY users call 711).

It is also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we will send you a letter that lists any other medical or drug coverage we know about. Read over this information carefully. If it is correct, you do not need to do anything. If the information is not correct, or if you have other coverage that is not listed, please call Member Services at 1-833-388-8168 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first ("the primary payer") pays up to the limits of its coverage. The insurance that pays second ("secondary payer") only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

CHAPTER 1: *Get started as a member*

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
 - If you are under 65 and disabled and you (or your family member) are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
 - If you are over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

CHAPTER 2 Phone numbers and resources**CHAPTER 2*****Phone numbers and resources*****SECTION 1 Clever Care Breathe+ contacts**

For help with claims, billing, or member card questions, call or write to Clever Care Breathe+ Member Services at 1-833-388-8168 (TTY users call 711). We will be happy to help you.

Member Services – Contact Information

Call	1-833-388-8168 Calls to this number are free. October 1st through March 31st 8 am to 8 pm, seven days a week; April 1st through September 30th 8 am to 8 pm, Monday through Friday Member Services (1-833-388-8168) (TTY users call 711) also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. October 1st through March 31st 8 am to 8 pm, seven days a week; April 1st through September 30th 8 am to 8 pm, Monday through Friday
Fax	1-657-276-4720
Write	Clever Care Health Plan 7711 Center Ave., Suite 100 Huntington Beach, CA 92647 customerservice@ccmapd.com
Website	clevercarehealthplan.com

CHAPTER 2 Phone numbers and resources**How to ask for a coverage decision or appeal about your medical care**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D drugs. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care or Part D drugs, go to Chapter 9 for more information.

Coverage Decisions and Appeals for Medical Care – Contact Information

Call	1-833-388-8168 Calls to this number are free. October 1st through March 31st 8:00 A.M. to 8:00 P.M., seven days a week; April 1st through September 30th 8:00 A.M. to 8:00 P.M., Monday through Friday Member Services (1-833-388-8168) (TTY users call 711) also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. October 1st through March 31st 8:00 A.M. to 8:00 P.M., seven days a week; April 1st through September 30th 8:00 A.M. to 8:00 P.M., Monday through Friday
Fax	1-657-276-4715
Write	Clever Care Health Plan Attn: Grievance & Appeals 7711 Center Ave., Suite 100 Huntington Beach, CA 92647 customerservice@ccmapd.com
Website	clevercarehealthplan.com

Coverage Decisions and Appeals for Part D drugs – Contact Information

Call	1-866-693-4620 Calls to this number are free. October 1st through March 31st 8:00 A.M. to 8:00 P.M., seven days a week; April 1st through September 30th 8:00 A.M. to 8:00 P.M., Monday through Friday
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CHAPTER 2 Phone numbers and resources**Coverage Decisions and Appeals for Part D drugs – Contact Information**

TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free and will be recorded. October 1st through March 31st 8:00 A.M. to 8:00 P.M., seven days a week; April 1st through September 30th 8:00 A.M. to 8:00 P.M., Monday through Friday
Fax	1-800-378-0323
Write	CVS Caremark P.O. Box 52066 Phoenix, AZ 85072
Website	caremark.com

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 9.

Complaints about Medical Care – Contact Information

Call	1-833-388-8168 Calls to this number are free. October 1st through March 31st 8:00 A.M. to 8:00 P.M., seven days a week; April 1st through September 30th 8:00 A.M. to 8:00 P.M., Monday through Friday
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. October 1st through March 31st 8:00 A.M. to 8:00 P.M., seven days a week; April 1st through September 30th 8:00 A.M. to 8:00 P.M., Monday through Friday
Fax	1-657-276-4715

CHAPTER 2 Phone numbers and resources**Complaints about Medical Care – Contact Information**

Write	Clever Care Health Plan Attn: Grievance & Appeals 7711 Center Ave., Suite 100 Huntington Beach, CA 92647
Medicare website	To submit a complaint about Clever Care Breathe+ directly to Medicare, go to https://www.Medicare.gov/my/medicare-complaint .

How to ask us to pay our share of the cost for medical care or a drug you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 7 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 9 for more information.

Payment Requests – Contact Information

Call	1-866-693-4620	
	October 1st through March 31st 8 am to 8 pm, seven days a week; April 1st through September 30th 8 am to 8 pm, Monday through Friday	
	Calls to this number are free.	
TTY	711	
	This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.	
	Calls to this number are free. October 1st through March 31st 8 am to 8 pm, seven days a week; April 1st through September 30th 8 am to 8 pm, Monday through Friday	
Fax	Medical: 1-657-276-4715	Pharmacy: 1-800-378-0323
Write	Medical: Clever Care Health Plan Attn: Grievance & Appeals 7711 Center Ave., Suite 100 Huntington Beach, CA 92647	Pharmacy: CVS Caremark P.O. Box 52066 Phoenix, AZ 85072
Website	clevercarehealthplan.com	

CHAPTER 2 Phone numbers and resources

SECTION 2 Get help from Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information

Call	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at https://www.Medicare.gov/talk-to-someone .
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044

CHAPTER 2 Phone numbers and resources**Medicare – Contact Information****Website**

www.medicare.gov

- Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide.
- Find Medicare-participating doctors or other health care providers and suppliers.
- Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits).
- Get Medicare appeals information and forms.
- Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals.
- Look up helpful websites and phone numbers.

You can also visit Medicare.gov to tell Medicare about any complaints you have about Clever Care Breathe+.

To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In California, the SHIP is called Health Insurance Counseling & Advocacy Program (HICAP).

HICAP is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

HICAP counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and straighten out problems with your Medicare bills. Health Insurance Counseling & Advocacy Program (HICAP) counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices, and answer questions about switching plans.

Health Insurance Counseling & Advocacy Program (HICAP) Contact Information**Call**

1-800-434-0022

CHAPTER 2 Phone numbers and resources**Health Insurance Counseling & Advocacy Program (HICAP) Contact Information**

TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	California Department of Aging 1300 National Drive, Suite 200 Sacramento, CA 95834-1992
Website	aging.ca.gov/hicap

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For California, the Quality Improvement Organization is called Livanta .

Livanta has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. Livanta is an independent organization. It is not connected with our plan.

Contact Livanta in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

Livanta (California Quality Improvement Organization)

Call	1-877-588-1123 8 am to 5 pm, Monday through Friday; 11 am to 3 pm, Saturday and Sunday; and 7 a.m. to 3:30 p.m. on holidays.
TTY	1-855-887-6668 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701

CHAPTER 2 Phone numbers and resources**Livanta (California Quality Improvement Organization)****Website**

livantaqio.com

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment. Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, contact Social Security to let them know.

Social Security– Contact Information

Call	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
Website	www.ssa.gov

SECTION 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. . Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

CHAPTER 2 Phone numbers and resources

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and Medicare Savings Programs, contact Medi-Cal.

Medi-Cal – Contact Information

Call	1-800-541-5555 Available 8:00 am to 5:00 pm, Monday through Friday; excluding state holidays.
TTY	This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	California Department of Health Care Services Medi-Cal Managed Care P.O. Box 997413, MS 4400 Sacramento, CA 95899-7413
Website	dhcs.ca.gov

SECTION 7 Programs to help people pay for prescription drugs

The Medicare website (<https://www.medicare.gov/basics/costs/help/drug-costs>) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare

Medicare and Social Security have a program called Extra Help that can help pay drug costs for people with limited income and resources. If you qualify, you get help paying for your Medicare drug plan's monthly plan premium, yearly deductible, and copayments. Extra Help also counts toward your out-of-pocket costs.

If you automatically qualify for Extra Help, Medicare will mail you a purple letter to let you know. If you do not automatically qualify, you can apply anytime. To see if you qualify for getting Extra Help:

- Visit <https://secure.ssa.gov/i1020/start> to apply online
- Call Social Security at 1-800-772-1213. TTY users call 1-800-325-0778.

When you apply for Extra Help, you can also start the application process for a Medicare Savings Program (MSP). These state programs provide help with other Medicare costs. Social

CHAPTER 2 Phone numbers and resources

Security will send information to your state to initiate an MSP application, unless you tell them not to on the Extra Help application.

If you qualify for Extra Help and you think that you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of the right copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- Call Member Services at 1-833-388-8168 (TTY users call 711) if you would like to request assistance with obtaining best available evidence, or if you want to provide evidence.
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make the payment directly to the state. Call Member Services at 1-833-388-8168 (TTY users call 711) if you have questions.

What if you have Extra Help and coverage from a State Pharmaceutical Assistance Program (SPAP)?

Many states offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's Extra Help pays first.

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the AIDS Drug Assistance Program (ADAP).

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call California's ADAP Program at 1-844-421-7050.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide drug coverage to its members.

- In California, the State Pharmaceutical Assistance Program is AIDS Drug Assistance Program (ADAP).

AIDS Drug Assistance Program (ADAP) – Contact Information

Call	1-844-421-7050
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CHAPTER 2 Phone numbers and resources**AIDS Drug Assistance Program (ADAP) – Contact Information**

Write	California Department of Public Health, Center for Infectious Diseases, Office of AIDS MS 0500, P.O. Box 997377 Sacramento, CA 95899-7377
Website	https://adap.directory/california

The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** To learn more about this payment option, call Member Services at 1-833-388-8168 (TTY users call 711) or visit www.Medicare.gov.

Medicare Prescription Payment Plan – Contact Information

Call	1-833-388-8168 Calls to this number are free. October 1st through March 31st 8 am to 8 pm, seven days a week; April 1st through September 30th 8 am to 8 pm, Monday through Friday Member Services (1-833-388-8168) (TTY users call 711) also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. October 1st through March 31st 8 am to 8 pm, seven days a week; April 1st through September 30th 8 am to 8 pm, Monday through Friday
Fax	1-657-276-4720

CHAPTER 2 Phone numbers and resources**Medicare Prescription Payment Plan – Contact Information**

Write	Clever Care Health Plan 7711 Center Ave., Suite 100 Huntington Beach, CA 92647
Website	clevercarehealthplan.com

SECTION 8 Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation’s railroad workers and their families. If you get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information

Call	1-877-772-5772 Calls to this number are free. Press “0,” you may speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press “1”, you may access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are <i>not</i> free.
Website	https://RRB.gov

SECTION 9 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner’s) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at 1-833-388-8168 (TTY users call 711) with any questions.

CHAPTER 2 Phone numbers and resources

You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's benefits administrator**. The benefits administrator can help you understand how your current drug coverage will work with our plan.

CHAPTER 3

Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other healthcare facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies, equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4.

Section 1.2 Basic rules for your medical care to be covered by our plan

As a Medicare health plan, Clever Care Breathe+ must cover all services covered by Original Medicare and follow Original Medicare's coverage rules.

Clever Care Breathe+ will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care physician (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 for more information).

CHAPTER 3 Using our plan for your medical services

- In most situations, your network PCP must give you approval in advance (a referral) before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information, go to Section 2.3.
- You do not need referrals from your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2.
- **You must get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who is not part of our plan's network) won't be covered. This means you have to pay the provider in full for services you get. Here are 3 exceptions:
 - Our plan covers emergency care or urgently needed services you get from an out-of-network provider. For more information, and to see what emergency or urgently needed services are, go to Section 3.
 - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. In this situation, you pay the same as you'd pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
 - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you are outside our plan's service area and get dialysis from a provider that's outside our plan's network, your cost sharing cannot be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.

SECTION 2 Use providers in our plan's network to get medical care

Section 2.1 You must choose a Primary Care Physician (PCP) to provide and oversee your medical care

What is a PCP and what does the PCP do for you?

When you join our plan, you must choose a plan provider to be your Primary Care Physician (PCP). Your PCP will be a licensed health care professional who will be your partner in health. Choose from physicians specializing in family practice, general practice, or internal medicine.

Your PCP will provide and coordinate your medical care; you should have all of your past medical records sent to your PCP's office. You will see your PCP first for most of your routine health care needs. Your PCP will also arrange or coordinate the rest of the covered services you get as a member of our plan, including but not limited to:

CHAPTER 3 Using our plan for your medical services

- X-rays
- Laboratory tests
- Therapies
- Care from a specialist
- Hospital admissions, and
- Follow-up care

Coordinating your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, you must get written approval in advance from your PCP (such as giving you a referral to see a specialist). In some cases, your PCP, or a specialist, or other provider you're seeing, will need to obtain prior authorization (prior approval) from us for certain types of covered services and items. See Chapter 4 of this booklet for services and items that require prior authorization.

How to choose a PCP?

When you enroll in our plan, you must first select a Medical Group or Independent Physician Association (IPA) from our network; then select a PCP that works with that group. When choosing a PCP, you are also choosing the hospitals and specialty network associated with that PCP. If there is a particular specialist or hospital you want to use, make sure they are part of the PCPs medical network. This is important because it will help to ensure you won't incur out-of-network costs associated with your care.

To choose your PCP, go to our website at clevercarehealthplan.com/provider. Be sure to write down the physician's name and ID number. This number will need to be included on your enrollment form. If you do not choose a PCP or if the PCP is not available with this plan, we will automatically assign one to you. A Member Services representative can also help you choose a PCP.

Once you are enrolled in the plan, we will send you a Clever Care member ID card. The name and office phone number of your PCP will be printed on this card.

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers, and you would need to choose a new PCP.

Many PCPs are affiliated with a Medical Group or Independent Physician Association (IPA) which includes access to a pre-defined list of specialists and other healthcare providers and facilities (e.g. hospital). If you select a PCP from a Medical Group or IPA, the PCP will direct you to seek care from within this group of providers and hospitals which act as a sub-network of providers.

If you wish to change your PCP and/or your assigned Medical Group/IPA, please call Member Services. Let us know if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Our representative will help make sure you can continue with the specialty care and other services you have been getting prior to when you changed your PCP. Our representatives will also check to be sure the PCP you want to switch to is accepting new patients.

Change requests must be received on or before the last day of the month (e.g., March 31). The change will take place on the first day of the next month (e.g., April 1).

CHAPTER 3 Using our plan for your medical services

You will be issued a new ID card showing the new information. If you use a PCP that is not printed on your ID card, you may incur a higher cost-sharing, or a claim may be denied.

Section 2.2 Medical care you can get without a PCP referral

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Flu shots (or vaccines), COVID-19 vaccines, Hepatitis B vaccines, and pneumonia vaccines as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you are either temporarily outside our plan's service area, or if it is unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) are not considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our plan's service area. If possible, please call Member Services at 1-833-388-8168 (TTY users call 711) before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. For example:

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions
- Orthopedists care for patients with certain bone, joint, or muscle conditions

If you have a condition that requires the expertise of a specialist or admission to a hospital within our network of providers, your PCP will complete the necessary paperwork required for the referral. Your Medical Group will mail the final determination of the referral to both you and your PCP. The letter will indicate the specialist and how to schedule your appointment.

Refer to Chapter 4, Section 2 for information about which services require prior authorization.

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors, and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

CHAPTER 3 Using our plan for your medical services

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to choose a new provider.
 - If your primary care or behavioral health provider leaves our plan, we will notify you if you visited that provider within the past 3 years.
 - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We will help you choose a new qualified in-network provider for continued care.
- If you are undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We will work with you so you can continue to get care.
- We will give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we will arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing.
- If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing. Your PCP should submit the proper prior authorization for the services to be covered by the Plan.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to the plan, or both. Please see Chapter 9.

Section 2.4 How to get care from out-of-network providers

To receive care from an out-of-network provider your doctor must request a written prior authorization for these services by submitting an authorization request to the Plan.

Note: Members are entitled to receive services from out-of-network providers for emergency or urgently needed services without prior authorization. This Plan covers dialysis services for ESRD members who have traveled outside the plans service area and are not able to access contracted ESRD providers.

CHAPTER 3 Using our plan for your medical services

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical emergency**What is a medical emergency and what should you do if you have one?**

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network.
- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Call 1-833-388-8168 October 1st through March 31st 8 am to 8 pm, seven days a week; April 1st through September 30th 8 am to 8 pm, Monday through Friday.

Covered if you have a medical emergency

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors giving you emergency care will decide when your condition is stable and when the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

CHAPTER 3 Using our plan for your medical services

However, after the doctor says it was not an emergency, we will cover additional care *only* if you get the additional care in one of these 2 ways:

- You go to a network provider to get the additional care, or
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

Section 3.2 Get care when you have an urgent need for services**What are urgently needed services?**

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you are either temporarily outside our plan's service area, or if it is unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits such as annual checkups are not considered urgently needed even if you are outside our plan's service area or our plan network is temporarily unavailable.

You should always try to obtain urgently needed services from the plan's network of providers. If a provider is unavailable or inaccessible and it is not reasonable to wait to obtain care when the provider becomes available, we will cover urgently needed services received from an out-of-network provider. A list of Urgent Care Centers is found in our Provider Directory at clevercarehealthplan.com/provider or you may call Member Services at the number on the back of this booklet.

When you need urgent care, contact your PCP or Medical Group first. If neither one is available, you may call Teladoc (available 24-hours a day) at 1-800-TELADOC (835-2362).

Our plan covers worldwide services outside the United States under the following circumstances: defined as urgent, emergent, and post-stabilization care.

Section 3.3 Get care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from our plan.

Visit clevercarehealthplan.com for information on how to get needed care during a disaster.

If you cannot use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescriptions at an out-of-network pharmacy. Go to Chapter 5, Section 2.4.

CHAPTER 3 Using our plan for your medical services

SECTION 4 What if you are billed directly for the full cost of covered services?

If you paid more than our plan cost sharing for covered services, or if you get a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 7 for information about what to do.

Section 4.1 If services are not covered by our plan, you must pay the full cost

Clever Care Breathe+ covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that are not covered by our plan or you get services out-of-network without authorization, you are responsible for paying the full cost of services.

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you are in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that is not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you are in a qualified clinical trial, you are only responsible for the in-network cost sharing for the services in that trial. If you paid more—for example, if you already paid the Original Medicare cost-sharing amount—we will reimburse the difference between what you paid and the in-network cost sharing. You will need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you do not need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do not need to be part of our plan's network (This does not apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you do not need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare, you will be responsible for paying all costs for your participation in the study.

CHAPTER 3 Using our plan for your medical services

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost-sharing you paid. Go to Chapter 7 for more information on submitting requests for payments.

Example of cost sharing in a clinical trial: Let's say you have a lab test that costs \$100 as part of the research study. Your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan. In this case, Original Medicare would pay \$80 for the test, and you would pay the \$20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation, (like a provider bill) to our plan. Our plan would then directly pay you \$10. This makes your net payment for the test \$10, the same amount you would pay under our plan's benefits.

When you are in a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free of charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies*, available at <https://www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf>. You can also call 1-800-MEDICARE (1-800-633-4227) TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care in a religious non-medical health care institution

Section 6.1 A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that is *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan only covers *non-religious* aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
 - – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Medicare inpatient hospital coverage limits may apply. Please refer to Chapter 4 of the benefits chart for additional information regarding the Medicare Inpatient Hospital coverage limits.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to

CHAPTER 3 Using our plan for your medical services

use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Clever Care Breathe+, you usually will not get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. You will not get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not get ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan do not count toward these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You did not get ownership of the item while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage Clever Care Breathe+ will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave Clever Care Breathe+ or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

What happens if you leave our plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you are again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4

Medical Benefits Chart (what is covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of Clever Care Breathe+. This section also gives information about medical services that are not covered and explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include:

- **Deductible:** the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about our deductibles for certain categories of services.)
- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program do not pay deductibles, copayments or coinsurance. If you are in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 Our plan has a deductible for certain types of services

Our plan has a deductible amount for certain services. Until you have paid the deductible amount, you must pay the full cost for inpatient hospital and/or inpatient psychiatric stays. Once you have paid the deductible amount, we will pay our share of the costs for these services, and you will pay your share. The Medical Benefits Chart shows the service category deductibles.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Section 1.3 What is the most you will pay for covered medical services?

Medicare Advantage Plans have limits on the total amount you have to pay out of pocket each year for in-network medical services that are covered by our plan. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2026 the MOOP amount is \$9,250.**

The amounts you pay for deductibles, copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for Part D drugs do not count toward your maximum out-of-pocket amount. If you reach the maximum out-of-pocket amount of \$0, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.4 Providers are not allowed to balance bill you

As a member of Clever Care Breathe+, you have an important protection because after you meet any deductibles, you only have to pay your cost-sharing amount when you get services covered by our plan. Providers cannot bill you for additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service, and even if there is a dispute and we do not pay certain provider charges.

Here is how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, \$15.00), you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
 - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
 - If you get covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or for urgently needed services outside the service area.)
- If you believe a provider has balance billed you, call Member Services at 1-833-388-8168 (TTY users call 711).

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services Clever Care Breathe+ covers and what you pay out of pocket for each service (Part D prescription coverage is in Chapter 5). The services listed in the Medical Benefits Chart are covered only when these are met:

- Your Medicare-covered services must be provided according to the Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You get your care from a network provider. In most cases, care you get from an out-of-network provider won't be covered, unless it is emergency or urgent care or unless our plan or a network provider gave you a referral. This means you pay the provider in full for out-of-network services you get.
- You have a primary care physician (a PCP) providing and overseeing your care.
- Some services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked in the Medical Benefits Chart in bold.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.
- We may also charge you administrative fees for missed appointments or for not paying your required cost sharing at the time of service. Call Member Services at 1-833-388-8168 (TTY users call 711) if you have questions regarding these administrative fees.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you are also treated or monitored for an existing

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

medical condition during the visit when you receive the preventive service, a copayment will apply for the care you got for the existing medical condition.

- If Medicare adds coverage for any services during 2026, either Medicare or our plan will cover those services.
- If you are within our plan's 2-month period of deemed continued eligibility, we will continue to provide all plan-covered benefits, and your cost-sharing amounts do not change during this period.

Important Benefit Information for People Who Qualify for Extra Help:

- If you get Extra Help to pay your Medicare drug program costs, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing.

Important Benefit Information for Enrollees with Chronic Conditions

- If you are diagnosed with any of the chronic condition(s) listed below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

- **Chronic alcohol use disorder and other substance use disorders:**
 - Alcohol use disorder
 - Opioid use disorder
 - Cannabis use disorder
 - Sedative, hypnotic, or anxiolytic use disorder
 - Cocaine use disorder
 - Other stimulant use disorder
 - Nicotine dependence
 - Inhalant use disorder
 - Other psychoactive substance use disorder
- **Autoimmune disorders:**
 - Psoriatic arthritis
 - Rheumatoid arthritis
 - Systemic lupus erythematosus
 - Dermatomyositis
 - Polymyositis
 - Polyarteritis nodosa
 - Polymyalgia rheumatica
 - Scleroderma
- **Cancer (excluding pre-cancer conditions or in-situ status)**
- **Cardiovascular disorders:**
 - Cardiac arrhythmias
 - Coronary artery disease
 - Chronic venous thromboembolic disorder
 - Peripheral vascular disease
- **Chronic heart failure**
- **Dementia**
- **Diabetes mellitus**
 - Type 1 diabetes mellitus
 - Type 2 diabetes mellitus
- **Chronic gastrointestinal disease:**
 - Hepatitis B
 - Hepatitis C
 - Pancreatitis
 - Inflammatory bowel disease
 - Non-alcoholic fatty liver disease (NAFLD)
- **Severe hematologic disorders:**
 - Aplastic anemia
 - Hemophilia
 - Immune thrombocytopenic purpura
 - Myelodysplastic syndrome
 - Sickle-cell disease (excluding sickle-cell trait)
 - Chronic venous thromboembolic disorder
- **HIV/AIDS**
- **Chronic lung disorders:**
 - Asthma
 - Chronic bronchitis
 - Emphysema
 - Chronic Obstructive Pulmonary Disease (COPD)
- **Chronic and disabling mental health conditions:**
 - Bipolar disorders
 - Major depressive disorders
 - Paranoid disorder
 - Schizophrenia
 - Schizoaffective disorder
- **Neurologic disorders:**
 - Fibromyalgia
 - Chronic fatigue syndrome
 - Spinal cord injury
 - Amyotrophic lateral sclerosis (ALS),
 - Epilepsy
 - Cerebral Palsy,
 - Extensive paralysis (that is, hemiplegia, quadriplegia, paraplegia, monoplegia)
 - Huntington's disease
 - Multiple sclerosis
 - Parkinson's disease
 - Polyneuropathy
 - Spinal stenosis
 - Stroke-related neurologic deficit
- **Stroke**
- **Post-organ transplantation care**

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

- **Chronic kidney disease (CKD):**
 - CKD requiring dialysis/End-stage renal disease (ESRD)
- **Immunodeficiency and Immunosuppressive disorders**
- **Conditions associated with cognitive impairment:**
 - Alzheimer's disease
- You are eligible for special supplemental benefits for the chronically ill (SSBCI) based on clinical criteria of a qualifying chronic condition as determined and confirmed by your physician. In some cases, you must also participate in one of the plan's Case Management Programs with defined goals and outcome measures.
- For more detail, go to the *Special Supplemental Benefits for the Chronically Ill* row in the Medical Benefits Chart below.
- Contact us to find out exactly which benefits you may be eligible for.



This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	20% coinsurance for Medicare-covered services. Prior authorization is required.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Acupuncture for chronic low back pain (continued)	
Acupuncture (routine) This plan covers, unlimited, in-network, routine (non-Medicare-covered) acupuncture services up to the annual plan maximum amount every year.	In-network No prior authorization or referral required. \$0 copayment per visit up to the plan maximum amount of \$2,000. After the plan pays the maximum benefit allowance for visits, you are responsible for any remaining costs. The annual plan maximum will not carry over to the next plan year.
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	20% coinsurance for each Medicare-covered ground ambulance trip (one-way). 20% coinsurance for each Medicare-covered air ambulance trip (one-way). Prior authorization is required for non-emergency ambulance transport.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
 Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. Note: Your first annual wellness visit cannot take place within 12 months of your <i>Welcome to Medicare</i> preventive visit. However, you do not need to have had a <i>Welcome to Medicare</i> visit to be covered for annual wellness visits after you have had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
 Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare covered bone mass measurement.
 Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for Medicare-covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	In-network 20% coinsurance for each Medicare-covered visit. Prior authorization and a referral are required.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
 Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
 Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
 Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • We cover only Manual manipulation of the spine to correct subluxation	In-network 20% coinsurance for each Medicare-covered visit. Prior authorization and a referral are required.
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	In-network Cost sharing for this service will vary depending on individual services provided under the course of treatment. Prior authorization and a referral are required.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
 Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover: Preventive dental services including: • Dental cleanings, two times per year • Oral exam(s), two times per year • Fluoride treatment, one time per year • Bitewing X-ray, two times per year Comprehensive dental services including, but not limited to: • Deep teeth cleaning • Fillings and repairs • Root canals (Endodontics) • Dental crowns • Implant • Bridges • Dentures • Extractions, and other services Our plan partners with Liberty Dental Plan to provide your dental benefits. Please note that some services require clinical review for prior authorization approval before treatment may begin. Certain documentation must be submitted with prior authorization requests and are clinically reviewed using the provided documentation to determine if they are indicated and appropriate based on industry standards, and that they meet all requirements specific to such services. Any treatment which, in the opinion of Liberty Dental, is not necessary or does not meet plan's criteria will not be covered. If	There is no requirement to stay in-network. For services received from an out-of-network provider, the Plan will pay up to the allowed amount for covered services, not exceeding the allowed amount. The member will be responsible for paying the difference between the provider's billed amount and the contracted allowances. Limitations and exclusions apply for certain dental services. A referral is not required for preventive services. A referral is required for comprehensive dental services. This plan provides a bi-annual allowance of \$1,200 for preventive and comprehensive services. The allowance is distributed starting on your effective date and July 1. The maximum annual benefit is \$2,400. After plan-paid benefits, you are responsible for the remaining cost and may use the flexible allowance as a form of payment. Any unused allowance on June 30 will roll over to the

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Dental services (continued) the required documentation is not provided, the service cannot be adequately reviewed and will therefore be denied. If the prior authorization is denied for any reason, the service will not be covered, and you will be responsible for all associated costs. Dental procedures for cosmetic or aesthetic reasons are not covered. Coverage is limited to services listed in the Schedule of Benefits. If a service is not listed, it is not included and is not covered. To locate a network provider, you may search the online provider directory at clevercarehealthplan.com/provider. It is recommended that you work with your dentist to check benefit coverage prior to obtaining dental services.	next six-month period and expire December 31. Excludes orthodontia. Prior authorization is required for implants and other services.
 Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
 Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
 Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions.	In-network 20% copayment for diabetic supplies. 20% coinsurance for each Medicare-covered diabetic therapeutic shoes or inserts. \$0 copayment for diabetes self-management training. Prior authorization is required.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, go to Chapter 12 and Chapter 3.) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at clevercarehealthplan.com. Generally, this plan covers any DME covered by Original Medicare from the brands and manufacturers on this list. We won't cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. If you're new to this plan and using a brand of DME not on our list, we'll continue to cover this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically appropriate after this 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.) If you (or your provider) don't agree with our plan's coverage decision, you or your provider can file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, go to Chapter 9.)	In-network 20% coinsurance for Medicare-covered durable medical equipment. Your cost sharing will not change after you are enrolled for 36 months. If you made 36 months of rental payment for oxygen equipment coverage before you enrolled in Clever Care Breathe+, your cost sharing in Clever Care Breathe+ is 20% coinsurance depending on the cost-sharing structure. Prior authorization is required.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Eastern Wellness services Our plan includes Eastern therapeutic therapy visits for any single or a combination of the following services from a contracted acupuncturist: • Cupping/Moxa • Tui Na • Gua Sha • MedX • Reflexology Each wellness service visit may not exceed 30 minutes in duration. Any service over 30 minutes will count as two visits.	In-network No prior authorization or referral required. \$0 copayment per visit up to the maximum 24 allowed visits per year. After the plan pays for the maximum allowed visits, you are responsible for any remaining costs. Any remaining visits will not carry over to the next plan year.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. Worldwide emergency coverage.	\$95 copayment for each visit to the emergency room. The copayment is \$0 if you are admitted to the hospital within 72 hours. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital for your care to continue to be covered OR you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost sharing you would pay at a network hospital. \$0 copayment and a combined \$100,000 annual maximum for emergency and/or urgently needed services outside the U.S. and its territories.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
 Health and wellness education programs This plan provides a Flex Benefits Mastercard® and will load it with a spending allowance every three months to help pay for eligible health and wellness related expenses: Over-the-Counter (OTC) items • OTC items are drugs and health related products that do not need a prescription. • Thousands of OTC items are covered by our plan, as allowed by Medicare. • Purchase items online or at a retail location. Specific name brands may not be available, and quantities may be limited or restricted. Herbal Supplements • This plan covers herbal supplements for the treatment or prevention of conditions such as allergies, anxiety, arthritis, back pain, eczema, fatigue, and more. • You must purchase supplements from a network supplier. A full list of eligible herbal supplements can be found on our website, clevercarehealthplan.com. Fitness Activities The flexible allowance can be used for qualifying activities including: • Gym membership– the monthly cost of your single person gym membership, if it’s “stand-alone” – meaning the primary purpose is to provide exercise equipment and orientation of the facility. Personal trainers are not allowed. • General access to a public sport facility– the access fee for using a public swimming pool or tennis court. For golf, only the green fee or the fee for using a public driving range is allowed. • Group fitness classes– fee for taking a group exercise class (e.g., tai chi, dance, yoga, or Pilates) with a formal, qualified instructor. Private classes or lessons are not allowed. Membership-based facilities, like golf clubs, country clubs, or massage/spas <u>do not</u> qualify even if they include gym access. In addition, the allowance cannot be used for walking/guided	In-network \$0 copayment up to the maximum plan allowance amount. You choose how to spend the allowance from the list of eligible services. Pay for services using the Flex Benefits MasterCard®. This plan provides a quarterly allowance of \$600; the maximum annual allowance is \$2,400. The allowance is distributed starting on your effective date then on April 1, July 1 and/or October 1. Any unused allowance on March 30, June 30 or September 30 will roll over to the next quarter and expire December 31. After plan-paid benefits, you are responsible for the remaining cost. Purchases made prior to the last day of the quarter will be deducted from current quarterly balance. Purchases made on the last day of the quarter will be deducted from next quarterly balance. Returns must be initiated by the 25th day of the last month in the quarter to allow for processing. (Example: March 25th for the first quarter of the

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Health and wellness education programs (continued) tours or paid to a private residence or instructor. All requests are subject to plan approval. The allowance may not be used for initiation or registration fees, prorated fees, annual fees, account freeze fees, maintenance fees and any miscellaneous fees or other penalties, equipment purchase or rental. Lastly, the flex benefit allowance cannot be used to purchase merchandise at a facility. Dental, Vision and/or Hearing • Allowance may be used to pay for services beyond the plan's annual allowance. Refer to the Dental services, Vision services, or Hearing services sections in this chart for details. Groceries • Allowance may be used to purchase healthy food and produce items <u>only if</u> the member has an eligible chronic condition. • The chronic condition <u>must be verified</u> by the Plan and the member's PCP. Refer to the Help with Certain Chronic Conditions section in this chart for details. The Flex card will be mailed shortly after enrollment in our plan. Before using the card, you will need to activate it by calling (877) 205-8005 (TTY: 711) or visit CleverCare.NationsBenefits.com/activate. You will not receive a PIN for your card; so, always select the “Credit” option not “Debit” when making a purchase. Track your allowance spending and balance using the Benefits Pro App or visit CleverCare.NationsBenefits.com. Some of our network partners may require a minimum purchase amount for shipping. Each vendor who accepts the Flex Benefits card may have their own return policy. Members will be bound to the vendor’s policy. If you need help, call Member Services at (833) 388-8168 (TTY: 711).	year.) Members will only get credit for items returned within the same quarter they were purchased. Alcohol and tobacco products are excluded from the flexible health & wellness allowance.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Healthcare welcome kit This plan provides a healthcare wellness kit to all enrolled members. The kit is designed to support lung health. Items include: • one air purifier • one replacement filter • lung health education material and more Kits will be shipped to your home approximately 30 days after enrollment.	There is no coinsurance or, copayment for the Healthcare welcome kit. Additional filters may be purchased using your OTC Flex Benefit allowance.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Hearing services Diagnostic hearing and balance evaluations performed by your PCP to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. This plan covers additional hearing services not covered by Original Medicare, including: • Routine a hearing exam • Hearing aids (one per ear, per year) You must obtain a fitting for hearing aids through NationsHearing. Please contact NationsHearing by phone at (866) 304-7577 (TTY:711) for more information or to schedule an appointment. Hearing aid benefit includes: • Three (3) follow-up visits within first year of initial fitting date • 60-day trial period from date of fitting • 60 batteries per year per hearing aid (3-year supply) • 3-year manufacturer repair warranty • One-time replacement coverage for lost, stolen, or damaged hearing aid • First set of ear molds (when needed)	In-network \$0 copayment for Medicare-covered hearing exam. \$0 copayment for one routine hearing exam, per year from a network provider. \$0 copay up to the allowance amount for hearing aids. This plan provides an annual allowance of \$600 per ear, per year for hearing aids. After plan-paid benefits, you are responsible for the remaining cost and may use the flexible allowance as a form of payment. Any unused allowance will expire December 31. Hearing aids are available through NationsHearing and limited to specific devices based on your hearing needs. A deductible applies for a one-time replacement for lost, stolen or damaged hearing aids.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Help with Certain Chronic Conditions Enrollees with a chronic condition listed below and meet certain criteria may be eligible for supplemental benefits for the chronically ill. Not all members will qualify for these special supplemental benefits. Eligibility depends on approval by Clever Care Health Plan. Diagnosis limitations apply. Conditions include: • Autoimmune disorders • Cancer • Cardiovascular disorders • Chronic alcohol or drug dependency • Chronic and disabling mental health conditions • Chronic gastrointestinal disease • Chronic heart failure • Chronic kidney disease • Chronic lung disorders • Conditions associated with cognitive impairment • Dementia • Diabetes mellitus • HIV/AIDS • Immunodeficiency and immunosuppressive disorders • Neurologic disorders • Post-organ transplant care • Severe hematologic disorders • Stroke To be eligible, chronically ill members may participate in a case management program with defined activities, goals, and outcome measures. In-home Safety Assessments are limited to those who meet fall risk criteria, gait, balance, or agility challenges. You must use the plan's contracted vendors. Alcohol and tobacco products are excluded from the grocery allowance.	In-network <u>Food & Produce (Grocery)</u> \$0 copayment. After approval by the Plan, the Health & Wellness flexible allowance of \$600 per quarter, will be made available to purchase approved healthy food and produce items. <u>Meals for Chronic Conditions</u> \$0 copay for meal assistance up to 3 meals per day for 14 days; not to exceed 42 meals per year for members who qualify. <u>Social Needs Benefits</u> \$0 copay for companionship services rendered by non-clinical personal caregivers. Services are limited to 24, four-hour shifts (96 total hours). <u>Telemonitoring Service</u> \$0 copay for a device to monitor medical and other health data. <u>In-home Safety Assessment</u> \$0 copay for up to two assessments per year.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
	<u>In-home Support Services</u> \$0 copay for services to assist with activities of daily living. Limited to 40 hours per year. <u>Support for Caregivers</u> \$0 copay for respite care. Limited to 40 hours of caregiving per year. Prior authorization is required.
 HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months. If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	In-network \$0 copay for each Medicare-covered home health service. Prior authorization and a referral are required.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	In-network 20% coinsurance of each Medicare-covered service. Prices may change on a quarterly basis, but cost sharing will never exceed 20% or \$35 for insulin. You continue to make payments until the out-of-pocket maximum is reached. Prior authorization is required.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You will be billed Original Medicare cost sharing. For services covered by Medicare Part A or B not related to your terminal prognosis: If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Clever Care Breathe+.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Hospice care (continued) For services covered by Clever Care Breathe+ but not covered by Medicare Part A or B: Clever Care Breathe+ will continue to cover plan-covered services that aren't covered under Part A or B whether or not they are related to your terminal prognosis. You pay our plan cost-sharing amount for these services. For drugs that may be covered by our plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they are related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4). Note: If you need non-hospice care (care that is not related to your terminal prognosis), contact us to arrange the services.	
 Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 7 for more information.	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Clever Care provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells starts only with the fourth pint of blood you need. You must either pay the costs for the	In-network The following Medicare defined amounts are for 2026. Deductible: \$1,736 \$0 copay per day for days 1–60 and 91 and more; \$434 copay per day for days 61–90. A benefit period begins the day you are admitted as an inpatient and ends when you have not received any inpatient care for 60 days in a row. If you get inpatient care at an out-of-network hospital for a non-emergency, you pay the full cost. If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital. Prior authorization is required.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Inpatient hospital care (continued) first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered starting with the first pint. • Physician services Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. Get more information in the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at https://www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	

Covered Service	What you pay
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. Our plan covers up to 90 days in a covered inpatient psychiatric facility. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	In-network The following Medicare defined amounts are for 2026. Deductible: \$1,736 \$0 copay per day for days 1–60 and 91 and more; \$434 copay per day for days 61–90. A benefit period begins the day you are admitted as an inpatient and ends when you have not received any inpatient care for 60 days in a row. If you get inpatient care at an out-of-network hospital for a non-emergency, you pay the full cost. Prior authorization and a referral are required.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay If you have used up your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. In some cases, we will cover certain services you get while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	You will pay the applicable cost-sharing for these services as though they were provided on an outpatient basis. Please refer to the applicable benefit section in this chart. You must pay the full cost if you stay in a skilled nursing facility longer than your plan covers.
 Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
 Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible people under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment. • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug	0-20% coinsurance of the Medicare-allowed amount for chemotherapy and other Part B drugs. Prices may change on a quarterly basis, but cost sharing will not exceed 20% or \$35 for insulin for a one-month's supply.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Medicare Part B prescription drugs (continued) • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv[®], and the oral medication Sensipar[®] • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions. (such as Epogen[®], Procrit[®], Retacrit[®], Epoetin Alfa, Aranesp[®], Darbepoetin Alfa, Mircera[®], or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) We also cover some vaccines under Part B and most adult vaccines under our Part D drug benefit. Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6.	
 Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	In-network 20% copayment per service; including group or individual therapy sessions. Prior authorization and a referral are required.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem. • Other outpatient diagnostic tests	In-network \$0 for basic radiology, surgical supplies, laboratory and blood tests. 20% coinsurance for X-rays, advanced diagnostic radiological services (MRI, CT, PET). 20% coinsurance for therapeutic radiological services. While you pay 20% for therapeutic radiology services, you will never pay more than your total out-of-pocket maximum for the year. If multiple services are received on the same day and at the same location the maximum copay amount applies. If you go to an out-of-network provider, you pay the full cost. Prior authorization and a referral are required.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at https://www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	In-network 20% coinsurance for outpatient hospital observation services Prior authorization is required.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, ask the hospital staff.	In-network 20% coinsurance for outpatient hospital services Prior authorization and a referral are required.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	In-network 20% coinsurance for outpatient group and/or individual therapy session. Prior authorization and a referral are required.
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language 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 20% coinsurance for each Medicare-covered rehabilitation therapy service. Prior authorization and a referral are required.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Outpatient substance use disorder services	In-network 20% coinsurance for each Medicare-covered counseling session. Prior authorization and a referral are required.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	In-network 20% coinsurance for Medicare-covered outpatient facility or ambulatory surgical center. Prior authorization and a referral are required.
Partial hospitalization services and Intensive outpatient services <i>Partial hospitalization</i> is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that is more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. <i>Intensive outpatient service</i> is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that is more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	In-network 20% coinsurance per stay for Medicare-covered partial hospitalization service and intensive outpatient service Prior authorization and a referral are required.
Personal Emergency Response System (PERS) Members who feel they are at risk of falls or emergencies in the home may request this mobile monitoring device. The service connects you to a 24-hour response center with the push of a button.	No prior authorization or referral required. \$0 copayment for one device per year.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders <u>if</u>: ○ You have an in-person visit within 6 months prior to your first telehealth visit ○ You have an in-person visit every 12 months while getting these telehealth services ○ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes <u>if</u>: ○ You're not a new patient and ○ The check-in isn't related to an office visit in the past 7 days and ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours <u>if</u>: ○ You're not a new patient and	In-network \$0 copayment for services performed by a PCP for Medicare-covered benefits. \$0 copayment for services performed by a specialist for Medicare-covered benefits. \$0 copayment for virtual telehealth services performed by your PCP or a specialist for Medicare-covered benefits. Prior authorization and a referral are required.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits (continued) ○ The evaluation isn't related to an office visit in the past 7 days and ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery	
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	In-network 20% coinsurance for Medicare-covered podiatry services. \$0 copayment per visit up to the maximum 12 allowed visits per year. Prior authorization and a referral are required.
 Pre-exposure prophylaxis (PrEP) for HIV prevention If you do not have HIV, but your doctor or other health care practitioner determines you are at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you are getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. A one-time hepatitis B virus screening.	There is no coinsurance, copayment, or deductible for the PrEP benefit.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
 Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to <i>Vision Care</i> later in this table for more detail.	In-network 20% coinsurance for Medicare-covered prosthetic devices and medical supplies. Prior authorization is required.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	In-network 20% coinsurance for each Medicare-covered pulmonary rehabilitation visit. Prior authorization and a referral are required.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Re-admission Prevention (Healing at Home) This plan offers a combined benefit to help with recovery immediately following discharge from an inpatient hospital or a skilled nursing facility. You will receive: • Personal care coordination • Home delivered meals • In-home support services Additionally, transportation is provided for medical appointments, pharmacy visits, or return trips from emergency or urgent care facilities, along with periodic well-check visits.	In-network \$0 copayment for services the following services provided post discharge from in-patient hospital or a skilled nursing facility (SNF). <i>Excludes discharge from an Ambulatory Surgical Center.</i> Call Member Services within 7 days of discharge in order for services to be authorized. <u>Care Coordination</u> \$0 copayment. You will receive a personal follow-up call from a case manager within 72 hours to help with medication review and education, and other support as needed. <u>Home Delivered Meals</u> \$0 copay for meal assistance up to 3 meals per day for 28 days; not to exceed 84 meals per year. <u>In-home support</u> \$0 copay to receive up to 60 hours of assistance with daily living (ADL) such as light household chores, dressing, minor yard work, medication pickup, registering for patient portal accounts, grocery shopping, and essential item procurement.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
 Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	Prior authorization is required. There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
 Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months. Eligible members are people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. <i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
 Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You are at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and are not considered high risk, we pay for a screening once. If you are at high risk (for example, you have continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.
 Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3), or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to Medicare Part B drugs in this table.	In-network \$0 copayment for kidney disease education services. 20% coinsurance of the Medicare-allowed amount for each Medicare-covered dialysis treatment. This includes both professional (nephrologist dialysis clinic visits) and dialysis facility visits. Dialysis received as a hospital inpatient will be covered under your hospital inpatient benefit. Prior authorization and a referral are required.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy and speech therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that is not a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital	In-network The following Medicare defined amounts are for 2026. For each stay in a Medicare-covered skilled nursing facility, you pay: \$0 copay per day for days 1–20; \$217 copay per day for days 21–100. No prior hospitalization is required. Prior authorization and a referral are required.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
 Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Special Supplemental Benefits for the Chronically Ill This plan offers special supplemental benefits for the chronically ill. Not all members qualify for these benefits. Refer to the Help with Certain Chronic Conditions row of this benefit table.	\$0 copayment for offered services, if a qualifying condition is verified by your PCP.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	In-network 20% coinsurance for each session. Prior authorization and a referral are required.
Telehealth services Telehealth visits can take place using your phone, tablet, or computer. • Video visit offered by your physician's office • Teladoc® visit (Teladoc Physicians can diagnose and treat non-emergent conditions and prescribe medications when medically necessary.) Teladoc physicians or mental health providers are available 24-hours a day for non-emergency health issues. Call 1-800-TELADOC (835-2362) or visit their website Teladoc.com to schedule an appointment.	In-network No prior authorization required. \$0 copayment per video visit performed by your PCP. \$0 copayment for a medical or mental health visit through the Teladoc network of providers.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Transportation rides (routine) The plan covers non - emergency ground transportation through CareCar. CareCar is available 24 hours a day, 7 days a week and can accommodate wheelchair or gurney transport. Trips are limited to a 30-mile radius, one-way, within the plan's service area to obtain health-related care and services under the plan's benefits. • A one-way trip (30 miles or fewer): counts as one ride • A one-way trip (over 30 miles) counts as two rides • A round trip (30 miles or fewer) counts as two rides • A round trip (over 30 miles) counts as four rides To schedule a ride, call 1-844-743-4344 or go online to getcarecar.com. You will receive a call 10-15 minutes prior to pick up by the driver or a CareCar representative to provide an ETA. Round trip rides should be scheduled at least 36 hours in advance. Rides scheduled less than 24 hours in advance are fulfilled to the best of CareCar's ability and are not guaranteed. Ride Cancellations Require a 24-hour Notice. • If a ride was scheduled, then canceled less than 24-hours in advance – we will deduct the appropriate number of rides (one-way equals one trip, round-trip equals two trips, regardless of mileage). For more information about plan-approved locations, please call Member Services at the number printed on the back cover of this booklet).	In-network No prior authorization required. \$0 copay for 48 one-way non-emergency rides per year.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
Urgently needed services A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside our plan's service area, or, even if you are inside our plan's service area, it is unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) are not considered urgently needed even if you are outside our plan's service area or our plan network is temporarily unavailable. Worldwide urgently needed coverage.	In-network \$0 copay for each urgently needed service. \$0 copayment and a combined \$100,000 annual maximum for emergency and/or urgently needed services outside the U.S. and its territories.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
 Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare does not cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. Vision care (routine) • Routine eye exam • Eyewear (frames, lenses, or contacts) • Upgrades You must use a VSP Vision Care network provider.	In-network \$0 copay for each Medicare-covered eye exam to treat an eye condition. \$0 copay for Medicare-covered glaucoma screening. \$0 copay for Medicare-covered diabetic retinopathy. \$0 copay for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. Prior authorization is required. No referral required for routine exams. \$0 copay for one routine eye exam. This plan provides an annual allowance of \$350 \$0 copay up to the allowance amount for eyewear (frames, lenses, or contacts) . After plan-paid benefits, you are responsible for the remaining cost and may use the flexible allowance as a form of payment. Any unused allowance will expire December 31.

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Covered Service	What you pay
 Welcome to Medicare preventive visit Our plan covers the one-time <i>Welcome to Medicare</i> preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. Important: We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your <i>Welcome to Medicare</i> preventive visit.	There is no coinsurance, copayment, or deductible for the <i>Welcome to Medicare</i> preventive visit.

SECTION 3 **Services that are not covered by our plan (exclusions)**

This section tells you what services are excluded from Medicare coverage and therefore, are not covered by this plan.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances.
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Covered only under specific conditions
Custodial care Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing	Not covered under any condition
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (Go to Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home.	Not covered under any condition
Home-delivered meals	Not covered under any condition
Homemaker services include basic household help, including light housekeeping or light meal preparation	Not covered under any condition
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Private room in a hospital	Covered only when medically necessary
Reversal of sterilization procedures and or non-prescription contraceptive supplies	Not covered under any condition
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered

CHAPTER 4 Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Covered only under specific conditions
Routine dental care, such as cleanings, fillings or dentures	Not covered under any condition
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids	One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens.
Routine foot care	Routine foot exams are covered up to the annual maximum number of visits. See the Medical Benefit chart above for more details. Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)
Routine hearing exams, hearing aids, or exams to fit hearing aids	Not covered under any condition
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition

CHAPTER 5:

Using plan coverage for Part D drugs

SECTION 1 Basic rules for our plan's Part D coverage

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

Our plan will generally cover your drugs as long as you follow these rules:

- You must have a provider (a doctor, dentist or other prescriber) write you a prescription, that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription (Go to Section 2) or you can fill your prescription through our plan's mail-order service.
- Your drug must be on our plan's Drug List (go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 in this chapter for more information)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

In most cases, your prescriptions are covered *only* if they are filled at our plan's network pharmacies. (Go to Section 2.5 for information about when we cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with our plan to provide your covered drugs. The term "covered drugs" means all the Part D drugs that are on our plan's Drug List.

Section 2.1 Network pharmacies

Find a network pharmacy in your area?

To find a network pharmacy, go to your *Pharmacy Directory*, visit our website (clevercarehealthplan.com/pharmacy), and/or call Member Services at 1-833-388-8168 (TTY users call 711).

You may go to any of our network pharmacies.

CHAPTER 5: Using plan coverage for Part D drugs

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you will have to find a new pharmacy in the network. To find another network pharmacy in your area, get help from Member Services at 1-833-388-8168 (TTY users call 711) or use the *Pharmacy Directory*. You can also find information on our website at clevercarehealthplan.com.

Specialized pharmacies

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty getting Part D drugs in an LTC facility, call Member Services at 1-833-388-8168 (TTY users call 711).
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. To locate a specialized pharmacy, go to your *Pharmacy Directory* clevercarehealthplan.com/pharmacy at 1-833-388-8168 (TTY users call 711) or call Member Services.

Section 2.2 Our plan's mail-order service

For certain kinds of drugs, you can use our plan's network mail-order services. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. These drugs are marked as **mail-order drugs** in our Drug List.

Our plan's mail-order service allows you to order **at least a 30-day supply of the drug and no more than a 100-day supply**.

To get information about filling your prescriptions by mail call Member Services or visit our website (phone number and website are listed on the back of this booklet).

Usually a mail-order pharmacy order will be delivered to you in no more than 10 days. If your order is delayed, please call CVS Caremark at 1-866-693-4620.

New prescriptions the pharmacy gets directly from your doctor's office. The pharmacy will automatically fill and deliver new prescriptions it gets from health care providers, without checking with you first, if either:

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You can ask for automatic delivery of all new prescriptions at any time by calling 1-833-843-0559.

If you get a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

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If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling 1-833-843-0559.

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It is important to respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, contact us by calling 1-833-843-0559.

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you before shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, contact your pharmacy 14 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact us by calling 1-833-843-0559.

If you get a refill automatically by mail that you do not want, you may be eligible for a refund.

Section 2.3 How to get a long-term supply of drugs

Our plan offers 2 ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.) You may order this supply through mail order (see Section 2.3) or you may go to a retail pharmacy.

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Pharmacy Directory* clevercarehealthplan.com/pharmacy tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services at 1-833-388-8168 (TTY users call 711) for more information.
2. You can also get maintenance drugs through our mail-order program. Go to Section 2.3 for more information.

Section 2.4 Using a pharmacy that is not in our plan's network

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. We also have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. **Check first with Member Services** at 1-833-388-8168 (TTY users call 711) to see if there is a network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy only in these circumstances:

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- You are traveling within the United States and its territories and become ill, lose or run out of your prescription drugs.
- The prescription is for a medical emergency or urgent care.
- You are unable to obtain a covered drug in a timely manner within our service area because a network pharmacy that provides 24-hour service is not available within a 25-mile driving distance.
- You are filling a prescription for a covered drug that is not regularly stocked at an accessible network retail pharmacy (for example, an orphan drug or other specialty pharmaceutical).

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

SECTION 3 Your drugs need to be on our plan's Drug List

Section 3.1 The Drug List tells which Part D drugs are covered

Our plan has a *List of Covered Drugs* (formulary). In this *Evidence of Coverage*, we call it the **Drug List**.

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare. The Drug List only shows drugs covered under Medicare Part D.

We will generally cover a drug on our plan's Drug List as long as you follow the other coverage rules explained in this chapter and use of the drug or medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- Approved by the FDA for the diagnosis or condition for which it is being prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

Certain drugs may be covered for some medical conditions, but are considered non-formulary for other medical conditions. These drugs will be identified on our Drug List and on www.Medicare.gov, along with the specific medical conditions that they cover.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar

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alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Go to Chapter 12 for definitions of types of drugs that may be on the Drug List.

Over-the-Counter Drugs

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Member Services at 1-833-388-8168 (TTY users call 711).

Drugs that are not on the Drug List

Our plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7.1.)
- In other cases, we have decided not to include a particular drug on the Drug List.
- In some cases, you may be able to get a drug that is not on the Drug List. (For more information, go to Chapter 9.)

Section 3.2 six cost-sharing tiers for drugs on the Drug List

Every drug on our plan's Drug List is in one of six cost-sharing tiers. In general, the higher the tier, the higher your cost for the drug:

- Tier 1 includes Preferred Generic drugs. (Lowest cost tier.)
- Tier 2 includes Generic drugs.
- Tier 3 includes Preferred Brand drugs.
- Tier 4 includes Non-Preferred Drugs.
- Tier 5 includes Specialty Tier. (Highest cost tier.)
- Tier 6 includes Select Care drugs

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

Section 3.3 How to find out if a specific drug is on the Drug List

To find out if a drug is on our Drug List, you have these options:

- Check the most recent Drug List we provided electronically.
- Visit our plan's website (clevercarehealthplan.com/druglist). The Drug List on the website is always the most current.
- Call Member Services at 1-833-388-8168 (TTY users call 711) to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.

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- Use our plan's "Real-Time Benefit Tool" (clevercarehealthplan.com) to search for drugs on the Drug list to get an estimate of what you will pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Member Services at 1-833-388-8168 (TTY users call 711).

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once on our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Section 4.2 Types of restrictions

If there is a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Member Services at 1-833-388-8168 (TTY users call 711) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (Go to Chapter 9.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Member Services at 1-833-388-8168 (TTY users call 711) or on our website clevercarehealthplan.com.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, our plan may require you to try Drug A first. If Drug A does not work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**. Our plan's step therapy criteria can be obtained by calling Member Services at 1-833-388-8168 (TTY users call 711) or on our website clevercarehealthplan.com/formulary.

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Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

SECTION 5 What you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take that isn't on our Drug List has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.

If your drug isn't on the Drug List or is restricted, here are options for what you can do:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can ask for an **exception** and ask our plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, our plan must provide a temporary supply of a drug you are already taking. This temporary supply gives you time to talk with your provider about the change.

To be eligible for a temporary supply, the drug you take **must no longer be on our plan's Drug List OR is now restricted in some way.**

- **If you are a new member**, we will cover a temporary supply of your drug during the first **90 days** of your membership in our plan.
- **If you were in our plan last year**, we will cover a temporary supply of your drug during the first **90 days** of the calendar year.
- This temporary supply will be for a maximum of 30 days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who have been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:**

We will cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

For questions about a temporary supply, call Member Services at 1-833-388-8168 (TTY users call 711).

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During the time when you are using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Member Services at 1-833-388-8168 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

You and your provider can ask our plan to make an exception and cover the drug in the way you would like it covered. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception. For example, you can ask our plan to cover a drug even though it is not on our plan's Drug List. Or you can ask our plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you take will be removed from the formulary or restricted in some way for next year, we will tell you about any change before the new year. You can ask for an exception before next year and we will give you an answer within 72 hours after we get your request (or your prescriber's supporting statement). If we approve your request, we will authorize coverage for the drug before the change takes effect.

If you and your provider want to ask for an exception, go to Chapter 9, Section 6.4 to learn what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Section 5.1 What to do if your drug is in a cost-sharing tier you think is too high

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Member Services at 1-833-388-8168 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask our plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception to the rule.

If you and your provider want to ask for an exception, go to Chapter 9, Section 6.4 for what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

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Drugs in our Tier 5 are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

SECTION 6 Our Drug List can change during the year

Most changes in drug coverage happen at the beginning of each year (January 1). However, during the year, our plan can make some changes to the Drug List. For example, our plan might:

- **Add or remove drugs from the Drug List**
- **Move a drug to a higher or lower cost-sharing tier**
- **Add or remove a restriction on coverage for a drug**
- **Replace a brand name drug with a generic version of the drug**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product**

We must follow Medicare requirements before we change our plan's Drug List.

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. Sometimes you will get direct notice if changes are made to a drug that you take.

Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**
 - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
 - We will make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List.
 - We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List with advance notice.**
 - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or lower cost-sharing tier and with the same or fewer restrictions.

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- We will make these changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
- We will tell you at least 30 days before we make the change, or tell you about the change and cover an 30-day fill of the version of the drug you are taking.
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
 - Sometimes a drug can be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you take that drug, we will tell you after we make the change.
- **Making other changes to drugs on the Drug List.**
 - We may make other changes once the year has started that affect drugs you are taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
 - We will tell you at least 30 days before we make these changes, or tell you about the change and cover an additional 30-day fill of the drug you are taking.

If we make changes to any of the drugs you take, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or asking for a coverage decision to satisfy any new restrictions on the drug you take. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you take. For more information on how to ask for a coverage decision, including an exception, go to Chapter 9.

Changes to the Drug List that do not affect you during this plan year

We may make certain changes to the Drug List that are not described above. In these cases, the change will not apply to you if you are taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that will not affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We will not tell you about these types of changes directly during the current plan year. You will need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to drugs you take that will impact you during the next plan year.

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SECTION 7 Types of drugs we do not cover

Some kinds of prescription drugs are *excluded*. This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself (except for certain excluded drugs covered under our enhanced drug coverage). If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 9.)

Here are 3 general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan cannot cover *off-label* use of a drug when the use is not supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

We offer additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. Our plan covers prescription cough medicine (benzonatate), vitamins (B12, D2, Folic Acid), and the drug to treat erectile dysfunction (limited to 6 tablets per 30 days). The amount you pay for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 6 of this document.)

If you **get Extra Help from Medicare** to pay for your prescriptions, Extra Help will not pay for the drugs that are not normally covered. (Go to our plan's Drug List or call Member Services at 1-833-388-8168 (TTY users call 711). If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

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If you get Extra Help to pay for your prescriptions, Extra Help will not pay for the drugs not normally covered. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 How to fill a prescription

To fill your prescription, provide our plan membership information (which can be found on your membership card) at the network pharmacy you choose. The network pharmacy will automatically bill our plan for *our* share of your drug cost. You need to pay the pharmacy *your* share of the cost when you pick up your prescription.

If you do not have our plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our plan enrollment information.

If the pharmacy cannot get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** You can then **ask us to reimburse you** for our share. Go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all our rules for coverage described in this chapter.

Section 9.2 As a resident in a long-term care (LTC) facility

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or uses a pharmacy that supplies drugs for all its residents. If you are a resident of a LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Pharmacy Directory* clevercarehealthplan.com/pharmacy to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Member Services at 1-833-388-8168 (TTY users call 711). If you are in an LTC facility, we must ensure that you are able to routinely get your Part D benefits through our network of LTC pharmacies.

If you are a resident in an LTC facility and need a drug that is not on our Drug List or restricted in some way, go to Section 5 for information about getting a temporary or emergency supply.

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Section 9.3 If you also have drug coverage from an employer or retiree group plan

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's benefits administrator**. They can help you understand how your current drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage pays first.

Special note about creditable coverage:

Each year your employer or retiree group should send you a notice that tells you if your drug coverage for the next calendar year is creditable.

If the coverage from the group plan is creditable, it means that our plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard drug coverage.

Keep any notices about creditable coverage because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from your employer or retiree plan's benefits administrator or the employer or union.

Section 9.4 If you're in a Medicare-certified hospice

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, laxative, pain medication or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

We conduct drug use reviews to help make sure our members get safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems like:

- Possible medication errors
- Drugs that may not be necessary because you take another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time

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- Prescriptions for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you take
- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.1 Drug Management Program (DMP) to help members safely use opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we plan on limiting how you get these medications or how much you can get, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You will have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a new decision. If we continue to deny any part of your request about the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you are getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.2 Medication Therapy Management (MTM) to help members manage their medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A

CHAPTER 5: *Using plan coverage for Part D drugs*

team of pharmacists and doctors developed the program for us to help make sure our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will get information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, notify us and we will withdraw you. For questions about this program, please contact Member Services at 1-833-388-8168 (TTY users call 711).

CHAPTER 6:

What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, please call Member Services at 1-833-388-8168 (TTY users call 711) and ask for the *LIS Rider*.

We use “drug” in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5 explains these rules. When you use our plan's “Real-Time Benefit Tool” to look up drug coverage (clevercarehealthplan.com/druglist), the cost you see shows an estimate of the out-of-pocket costs you are expected to pay. You can also get information provided by the “Real-Time Benefit Tool” by calling Member Services at 1-833-388-8168 (TTY users call 711).

Section 1.1 Types of out-of-pocket costs you may pay for covered drugs

There are 3 different types of out-of-pocket costs for covered Part D drugs that you may be asked to pay:

- **Deductible** is the amount you pay for drugs before our plan starts to pay our share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.2 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what does not count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments are included in your out-of-pocket costs

Your out-of-pocket costs **include** the payments listed below (as long as they are for covered Part D drugs, and you followed the rules for drug coverage explained in Chapter 5):

CHAPTER 6: What you pay for Part D drugs

- The amount you pay for drugs when you are in the following drug payment stages:
 - The Deductible Stage
 - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan
- Any payments for your drugs made by family or friends
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, and most charities

Moving to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$2,000 in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments are not included in your out-of-pocket costs

Your out-of-pocket costs **do not include** any of these types of payments:

- Drugs you buy outside the United States and its territories
- Drugs that are not covered by our plan
- Drugs you get at an out-of-network pharmacy that do not meet our plan's requirements for out-of-network coverage
- Prescription drugs and vaccines covered by Part A or Part B
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Drug Plan
- Payments you make toward prescription drugs not normally covered in a Medicare Drug Plan.
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling Member Services at 1-833-388-8168 (TTY users call 711).

Tracking your out-of-pocket total costs

- The *Part D Explanation of Benefits* (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches \$2,000, the *Part D EOB* will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

CHAPTER 6: What you pay for Part D drugs

SECTION 2 Drug payment stages for Clever Care Breathe+ members

There are 3 **drug payment stages** for your drug coverage under Clever Care Breathe+. How much you pay for each prescription depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Catastrophic Coverage Stage

SECTION 3 Your Part D Explanation of Benefits (EOB) explains which payment stage you are in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-Pocket Costs:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions through our plan during the previous month, we will send you a *Part D EOB*. The *Part D EOB* includes:

- **Information for that month.** This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what our plan paid, and what you and others paid on your behalf.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower cost sharing for each prescription claim, if applicable.

CHAPTER 6: What you pay for Part D drugs

Section 3.1 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
 - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that is not part of our plan's benefit.
 - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
 - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
 - If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you get the *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or you have questions, call Member Services at 1-833-388-8168 (TTY users call 711). Be sure to keep these reports.

SECTION 4 The Deductible Stage

The Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription for the year. When you are in this payment stage, **you must pay the full cost of your drugs** until you reach our plan's deductible amount, which is \$615 for 2026.

The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.

You will pay a yearly deductible of \$615 on drugs. **You must pay the full cost of your drugs** until you reach our plan's deductible amount. For all other drugs, you will not have to pay any deductible.

CHAPTER 6: What you pay for Part D drugs

The full cost is usually lower than the normal full price of the drug since our plan has negotiated lower costs for most drugs at network pharmacies. The full cost cannot exceed the maximum fair price plus dispensing fees for drugs with negotiated prices under the Medicare Drug Price Negotiation Program.

Once you pay \$615 for your drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, our plan pays its share of the cost of your covered drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

Our plan has six cost-sharing tiers

Every drug on our plan's Drug List is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Tier 1 includes Preferred Generic drugs. *(This is the lowest tier.)*
- Tier 2 includes Generic drugs.
- Tier 3 includes Preferred Brand drugs.
- Tier 4 includes Non-Preferred drugs.
- Tier 5 includes Specialty Tier drugs. *(This is the highest tier.)*
- Tier 6 includes Select Care drugs.

- Tier 3: You pay \$35 per month supply of each covered insulin product on this tier.
- Tier 4: You pay \$35 per month supply of each covered insulin product on this tier.
- Tier 5: You pay \$35 per month supply of each covered insulin product on this tier.

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy that offers standard cost sharing. Costs may be less at pharmacies that offer preferred cost sharing
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.4 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- Our plan's mail-order pharmacy

CHAPTER 6: What you pay for Part D drugs

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 and our plan's *Pharmacy Directory* (clevercarehealthplan.com/pharmacy).

Section 5.2 Your costs for a one-month supply of a covered drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

The amount of the copayment or coinsurance depends on which cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your costs for a one-month supply of a covered Part D drug

Tier	Standard retail in-network cost sharing (up to a 30-day supply)	Mail-order cost sharing (up to a 30-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; go to Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Cost-Sharing Tier 2 (Generic)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Cost-Sharing Tier 3 (Preferred Brand)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Cost-Sharing Tier 4 (Non-Preferred Drug)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance

CHAPTER 6: What you pay for Part D drugs

Cost-Sharing Tier 5 (Specialty)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Cost-Sharing Tier 6 (Select Care)	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment

You won't pay more than \$35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.

Go to Section 7 of this chapter for more information on Part D vaccines cost sharing for Part D vaccines.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply, if this will help you better plan refill dates.

If you get less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you are responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We calculate the amount you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you get.

Section 5.4 Your costs for a *long-term* (up to a 100-day) supply of a covered Part D drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a 100-day supply.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

CHAPTER 6: What you pay for Part D drugs**Your costs for a *long-term* (up to a 100-day) supply of a covered Part D drug**

Tier	Standard retail cost sharing (in-network) (up to a 100-day supply)	Mail-order cost sharing (up to a 100-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	25% coinsurance	25% coinsurance
Cost-Sharing Tier 2 (Generic)	25% coinsurance	25% coinsurance
Cost-Sharing Tier 3 (Preferred Brand)	25% coinsurance	25% coinsurance
Cost-Sharing Tier 4 (Non-Preferred Drug)	25% coinsurance	25% coinsurance
Cost-Sharing Tier 5 (Specialty)	25% coinsurance	25% coinsurance
Cost-Sharing Tier 6 (Select Care)	\$0 copayment	\$0 copayment

You won't pay more than \$70 for up to a 2-month supply or \$105 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach \$2,100

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach \$2,100. You then move to the Catastrophic Coverage Stage.

The Part D EOB you get will help you keep track of how much you, our plan, and any third parties have spent on your behalf during the year. Not all members will reach the \$2,100 out-of-pocket limit in a year.

We will let you know if you reach this amount. Go to Section 1.3 for more information on how Medicare calculates your out-of-pocket costs.

CHAPTER 6: What you pay for Part D drugs

SECTION 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the \$2,100 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs covered under our enhanced benefit.

SECTION 7 What you pay for Part D vaccines

Important message about what you pay for vaccines – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible. Go to our plan's Drug List or contact Member Services at 1-833-388-8168 (TTY users call 711) for coverage and cost-sharing details about specific vaccines.

There are 2 parts to our coverage of Part D vaccines:

- The first part is the cost of **the vaccine itself**.
- The second part is for the cost of **giving you the vaccine**. (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccine depend on 3 things:

1. Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).

- Most adult Part D vaccines are recommended by ACIP and cost you nothing.

2. Where you get the vaccine.

- The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.

3. Who gives you the vaccine.

- A pharmacist or another provider may give the vaccine in the pharmacy. Or a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccine can vary depending on the circumstances and what **drug payment stage** you are in.

- When you get a vaccine, you may have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you will be reimbursed the entire cost you paid.
- Other times when you get a vaccine, you pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you pay nothing.

CHAPTER 6: What you pay for Part D drugs

Below are 3 examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you pay nothing.
- For other Part D vaccines, you pay the pharmacy your coinsurance for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccine at your doctor's office.

- When you get the vaccine, you may have to pay the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any coinsurance for the vaccine (including administration).

Situation 3: You buy the Part D vaccine itself at the network pharmacy and take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you pay the pharmacy your coinsurance for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid.

CHAPTER 7: *Asking us to pay our share of a bill for covered medical services or drugs*

CHAPTER 7:***Asking us to pay our share of a bill for covered medical services or drugs*****SECTION 1 Situations when you should ask us to pay our share for covered services or drugs**

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may find you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs covered by our plan. Go to Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost sharing. First, try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted you still have the right to treatment.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. When you got emergency or urgently needed medical care from a provider who is not in our plan's network

Outside the service area, you can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases,

- You are only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care.
- If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
- You may get a bill from the provider asking for payment you think you do not owe. Send us this bill, along with documentation of any payments you already made.
 - If the provider is owed anything, we will pay the provider directly.

CHAPTER 7: Asking us to pay our share of a bill for covered medical services or drugs

- If you already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill our plan directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get covered services. We do not allow providers to add additional separate charges, called **balance billing**. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, but feel you paid too much, send us the bill along with documentation of any payment you made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

3. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out of pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork, such as receipts and bills, for us to handle the reimbursement.

4. When you use an out-of-network pharmacy to fill a prescription

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. Go to Chapter 5, Section 2.4 to learn about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount we would pay at an in-network pharmacy.

5. When you pay the full cost for a prescription because you don't have our plan membership card with you

If you do not have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

6. When you pay the full cost for a prescription in other situations

CHAPTER 7: Asking us to pay our share of a bill for covered medical services or drugs

You may pay the full cost of the prescription because you find the drug is not covered for some reason.

- For example, the drug may not be on our plan's Drug List, or it could have a requirement or restriction you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we will pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or pay a bill you got

You can ask us to pay you back by either calling us or sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within 365** of the date you got the service, item, or drug.

Mail your request for payment together with any bills or receipts, to us at this address:

Clever Care Health Plan
Attn: Claims Department
7711 Center Ave., Suite 100
Huntington Beach, CA 92647

CVS Caremark
Attn: Claims Department
P.O. Box 52066
Phoenix, AZ 85072

SECTION 3 We will consider your request for payment and say yes or no

When we get your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide the medical care or drug is covered and you followed all the rules, we will pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
- If we decide the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

CHAPTER 7: *Asking us to pay our share of a bill for covered medical services or drugs*

Section 3.1 If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9.

CHAPTER 8

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, large print, or other alternate formats, etc.)

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan can meet these accessibility requirements include but are not limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We provide written materials in these languages: English, Chinese (Traditional), Korean, Vietnamese, and Spanish. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about our plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services at 1-833-388-8168 (TTY users call 711).

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in our plan's network for a specialty are not available, it is our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go to get this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with a Grievance & Appeals representative at 1-833-388-8168. You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

本計劃必須確保所有服務（無論是臨床和非臨床）均以符合文化敏感度的方式提供，並使所有投保人（包括英語能力有限、閱讀能力有限、聽力障礙者或具有不同文化和種族背景

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者)皆可獲得這些服務。本計劃可能滿足這些方便取用要求的範例包括但不限於提供筆譯服務、口譯服務,或透過失聰專用電話裝置或聽障專線(TTY)(文字電話或失聰專用電話裝置)連線。

本計劃提供免費口譯服務,為非使用英語的會員解答疑問。如果您有需要,我們也可免費以點字版、大字版或其他替代格式為您提供資訊。按照規定,我們必須使用對您而言合適且方便取用的格式,為您提供本計劃福利相關資訊。若要以對您而言合適的方式從我們這裡取得資訊,請致電會員服務,電話是 1-833-808-8153 (普通話) 或者 1-833-808-8161 (粵語) (聽障專線(TTY)使用者請致電 711)。

本計劃必須為女性投保人提供相關選項,方便他們直接前往網絡內婦女健康專科醫生處進行婦女例行性和預防性的醫療保健服務。

如果本計劃網絡內沒有特定專科的醫療機構,本計劃有責任在網絡外尋找能為您提供必要護理服務的專科醫療機構。在這種情況下,您只需要支付網絡內分攤費用。如果您發現本計劃網絡內沒有專科醫生提供所需的服務,請致電本計劃諮詢相關資訊,以瞭解如何以網絡內分攤費用取得該服務。

如果無法透過對您而言合適且方便取用的格式從我們這裡取得資訊、到婦女健康專科醫生處看診或尋找網絡內專科醫生,請致電聯絡申訴與上訴代表 1-833-808-8153 (普通話) 或者 1-833-808-8161 (粵語) 以提出申訴。您也可致電 1-800-MEDICARE (1-800-633-4227) 向聯邦醫療保險(Medicare)提出申訴,或者直接向民權辦公室(1-800-368-1019,聽障專線(TTY) 1-800-537-7697)提出申訴。

우리 플랜은 임상 및 비임상의 모든 서비스가 문화적 요구를 충족하는 방식으로 제공되며, 또한 영어 능력이 제한적이거나 읽기 능력이 제한적이거나 청각 장애가 있거나 다양한 문화적, 민족적 배경을 가진 사람들을 포함한 모든 가입자가 이용할 수 있는 형태로 제공 되도록 조치할 의무가 있습니다. 우리 플랜이 이러한 이용 요구를 충족시킬 수 있는 방법에는 번역 서비스, 통역 서비스, 전신타자기 또는 TTY(문자 전화 또는 전신타자기 전화) 연결 제공 등이 있지만 이에 국한되지 않습니다.

영어를 사용하지 않는 가입자는 우리 플랜에 질문할 때 무료 통역사를 이용하실 수 있습니다. 또한 가입자가 원하시는 경우 점자, 큰 활자 또는 다른 대체 형식으로 작성된 정보를 무료로 제공해 드릴 수 있습니다. 우리는 가입자가 접근 가능하고 가입자에게 적절한 형식으로 플랜 혜택에 관한 정보를 제공해야 합니다. 귀하에게 적합한 방법으로 정보를 얻고자 하시면 회원 서비스에 1-833-808-8164 (TTY 사용자는 711)번으로 전화하시기 바랍니다.

우리 플랜은 여성 가입자에게 여성의 일상적 및 예방적 건강 관리 서비스를 위해 네트워크 내의 여성 건강 전문의에게 직접 접근할 수 있는 옵션을 제공하도록 되어 있습니다.

우리 플랜의 네트워크 내에서 전문 분야 서비스 제공자를 이용할 수 없는 경우, 귀하에게 필요한 서비스를 제공할 네트워크 외의 전문 서비스 제공자를 찾는 것은 우리 플랜의 책임입니다. 이 경우 귀하는 네트워크 내 비용 부담액만 지불합니다. 귀하에게 필요한 서비스를 제공하는 전문의가 우리 플랜의 네트워크 내에 없는 상황이라면, 우리 플랜에 전화하여 네트워크 내 비용 부담으로 해당 서비스를 받을 수 있는 곳을 알아보십시오.

우리 플랜으로부터 귀하에게 접근 가능하고 알맞은 형식으로 정보를 얻거나 여성 건강 전문의 또는 네트워크 내 전문의를 찾는데 어려움이 있는 경우 고충 및 이의 제기 담당자에게 1-833-808-8164 에 전화하여 고충을 제기하십시오. 또한 Medicare에 1-800-MEDICARE(1-800-633-4227)로 전화하거나 직접 민권실에 1-800-368-1019 또는 TTY 1-800-537-7697번으로 전화하여 불만을 제기하실 수도 있습니다.

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Nuestro plan debe garantizar que todos los servicios, tanto clínicos como no clínicos, se proporcionen de manera culturalmente competente y sean accesibles para todos los afiliados, incluidos quienes tengan un conocimiento limitado del inglés, habilidades limitadas de lectura, discapacidad auditiva o diversos orígenes culturales y étnicos. Algunos ejemplos de cómo nuestro plan puede cumplir con estos requisitos de accesibilidad incluyen, entre otros: prestación de servicios de traducción, servicios de interpretación o conexión TTY (teléfono de texto o teletipo).

Nuestro plan cuenta con servicios de intérpretes gratuitos disponibles para responder preguntas de miembros que no hablen inglés. También podemos brindarle información en braille, letra grande y otros formatos alternativos sin costo si lo necesita. Estamos obligados a brindarle información sobre los beneficios de nuestro plan en un formato que sea accesible y adecuado para usted. Para obtener información de parte nuestra de una manera que le sea conveniente, llame al Servicios a los Miembros al 1-833-388-8168, (usuarios de TTY llamen al 711).

Nuestro plan debe brindar a las mujeres inscritas la opción de acceso directo a un especialista en salud de la mujer dentro de la red para servicios de atención médica preventiva y de rutina para mujeres.

Si no hay proveedores de la red de nuestro plan disponibles para una especialidad, es responsabilidad de nuestro plan localizar proveedores especializados fuera de la red que puedan brindarle la atención necesaria. En este caso, solo pagará los costos compartidos dentro de la red. Si no hay especialistas en la red de nuestro plan que cubran un servicio que necesita, llame a nuestro plan para obtener información sobre adónde acudir para obtener este servicio al costo compartido dentro de la red.

Si tiene problemas para obtener información de nuestro plan en un formato accesible y adecuado para usted, consultar a un especialista en la salud de la mujer o encontrar un especialista dentro de la red, llame para presentar una queja ante un representante de quejas y apelaciones al 1-833-388-8168. También puede presentar una queja a Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente a la Oficina de Derechos Civiles, al 1-800-368-1019 o TTY 1-800-537-7697.

Chương trình của chúng tôi phải đảm bảo rằng tất cả các dịch vụ, cả lâm sàng và phi lâm sàng, được cung cấp một cách phù hợp về mặt văn hóa và có thể tiếp cận được với tất cả những người ghi danh, bao gồm cả những người có khả năng Anh ngữ hạn chế, kỹ năng đọc hạn chế, khiếm thính hoặc những người có văn hóa và nguồn gốc dân tộc khác nhau. Ví dụ về cách chương trình của chúng tôi có thể đáp ứng các yêu cầu về khả năng tiếp cận này bao gồm nhưng không giới hạn ở: cung cấp dịch vụ phiên dịch, dịch vụ thông dịch viên, máy điện báo hoặc kết nối TTY (điện thoại văn bản hoặc máy đánh chữ).

Chương trình của chúng tôi có dịch vụ thông dịch viên miễn phí để giải đáp thắc mắc của các hội viên không nói tiếng Anh. Chúng tôi cũng có thể cung cấp cho quý vị thông tin bằng chữ nổi, bản in cỡ chữ lớn hoặc các định dạng thay thế khác miễn phí nếu quý vị cần. Chúng tôi phải cung cấp cho quý vị thông tin về các quyền lợi của chương trình của chúng tôi ở định dạng có thể tiếp cận và phù hợp với quý vị. Để nhận thông tin từ chúng tôi theo cách phù hợp với quý vị, vui lòng gọi điện cho Dịch Vụ Hội Viên theo số 1-833-808-8163 (Người dùng TTY xin gọi 711).

Chương trình của chúng tôi phải cung cấp cho những người ghi danh là phụ nữ tùy chọn tiếp cận trực tiếp với một bác sĩ chuyên khoa về sức khỏe phụ nữ trong mạng lưới các dịch vụ chăm sóc sức khỏe dự phòng và thông thường cho phụ nữ.

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Nếu không có nhà cung cấp chuyên khoa trong mạng lưới chương trình của chúng tôi thì chương trình có trách nhiệm xác định các nhà cung cấp chuyên khoa ngoài mạng lưới để cung cấp cho quý vị các dịch vụ chăm sóc cần thiết. Trong trường hợp này, quý vị sẽ chỉ phải trả khoản chia sẻ chi phí trong mạng lưới. Nếu không có bác sĩ chuyên khoa nào trong mạng lưới chương trình của chúng tôi cung cấp dịch vụ mà quý vị cần, hãy gọi cho chương trình để biết thông tin về nơi đến để nhận dịch vụ với mức chia sẻ chi phí trong mạng lưới.

Nếu quý vị gặp bất kỳ khó khăn nào khi nhận thông tin từ chương trình của chúng tôi ở định dạng có thể tiếp cận được và phù hợp với quý vị, gặp một bác sĩ chuyên khoa sức khỏe phụ nữ hoặc tìm một bác sĩ chuyên khoa trong mạng lưới, hãy gọi điện để gửi đơn khiếu nại với một chuyên viên về Khiếu nại & Kháng nghị theo số 1-833-808-8163. Quý vị cũng có thể nộp đơn khiếu nại với Medicare bằng cách gọi số 1-800-MEDICARE (1-800-633-4227) hoặc trực tiếp với Văn phòng Dân quyền theo số điện thoại 1-800-368-1019 hoặc TTY 1-800-537-7697.

Section 1.2 We must ensure you get timely access to covered services and drugs

You have the right to choose a primary care provider (PCP) in our plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral. We do not require you to get referrals to go to network providers.

You have the right to get appointments and covered services from our plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a **Notice of Privacy Practice**, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*

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- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - We are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at our plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, call Member Services at 1-833-388-8168 (TTY users call 711).

Notice of Privacy Practices

Clever Care of Golden State Inc., a wholly owned subsidiary of Clever Care Health Plan, Inc. (herein referred to as Clever Care) is required by law to protect the privacy of your health information. We are required to provide you with this Notice of Privacy Practices, which explains how we may use information about you and when we can give out or “disclose” that information to others. You also have rights regarding your health information that is described in this notice. We are obligated to follow the terms outlined in this notice and to safeguard your health information in accordance with applicable federal and state privacy laws.

The terms “information” or “health information” in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide you, in our next annual distribution, with a revised notice or information about the material change and how to obtain a revised notice.

We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your health plan, we will post the revised notice on your health plan website, clevercarehealthplan.com. We reserve the right

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to make any revised or changed notice effective for information we already have and for information that we receive in the future.

Clever Care collects and maintains oral, written, and electronic information to administer our business and to provide products, services, and information of importance to our enrollees. We maintain physical, electronic, and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We permitted by law to use and disclose your protected health information (PHI) for purposes related to your treatment, payment for your health care and to operate our business. This includes sharing information with health care providers, pharmacies, and other entities involved in your care. For example, we may use or disclose your health information:

For Payment of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.

For Treatment. We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.

For Health Care Operations. We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice, and we may use the information for any lawful purpose.

To Provide You Information on Health-Related Programs or Products such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.

For Plan Sponsors. If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan

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administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.

For Underwriting Purposes. We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.

For Reminders. We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

As Required by Law. We may disclose information when required to do so by law.

To Persons Involved With Your Care. We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you provide verbal agreement, written authorization, or when you agree or do not object when given the opportunity. If you are incapacitated in an emergency or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.

For Public Health Activities such as reporting or preventing disease outbreaks to a public health authority.

For Reporting Victims of Abuse, Neglect or Domestic Violence to government authorities that are authorized by law to receive such information, including a social service or protective service agency.

For Health Oversight Activities to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.

For Judicial or Administrative Proceedings such as in response to a court order, search warrant or subpoena.

For Law Enforcement Purposes. We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

To Avoid a Serious Threat to Health or Safety to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

For Specialized Government Functions such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

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For Workers' Compensation as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.

For Research Purposes such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.

To Provide Information Regarding Decedents. We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

For Organ Procurement Purposes. We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes, or tissue to facilitate donation and transplantation.

To Correctional Institutions or Law Enforcement Officials if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.

To Business Associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by federal law.

Additional Restrictions on Use and Disclosure.

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:

- Alcohol and Substance Abuse
- Biometric Information
- Child or Adult Abuse or Neglect, including Sexual Assault
- Communicable Diseases
- Genetic Information
- HIV/AIDS
- Mental Health
- Minors' Information
- Prescriptions
- Reproductive Health
- Sexually Transmitted Diseases

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If the use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

We maintain physical, electronic, and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or “revoke” your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on your health plan ID card.

Our Responsibility

We are legally obligated to maintain the privacy and security of your protected health information. If a breach occurs that may have compromised the privacy or security of your information, we will notify you promptly as required by law. We are required to adhere to the duties and privacy practices outlined in this notice and to provide you a copy of the notice upon request.

What are Your Rights

The following are your rights with respect to your health information:

You have the right to ask to restrict uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **While we will make every effort to accommodate your request and will honor those consistent with our policies, please note that we are not required to agree to any restriction unless required by law.**

You have the right to ask to receive confidential communications of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you to confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.

You have the right to see and obtain a copy of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health

CHAPTER 8 Your rights and responsibilities

information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.

You have the right to ask to amend certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.

You have the right to receive an accounting of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.

You have the right to a paper copy of this notice. You may request a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on your website, clevercarehealthplan.com.

Exercising Your Rights

Contacting your Health Plan. If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on your health plan ID card or you may contact Member Services toll-free at 1-833-388-8168 (TTY: 711), 8 am to 8 pm, seven days a week, from October 1 through March 31, and 8 am to 8 pm, weekdays, from April 1 through September 30.

Submitting a Written Request.

You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records or requesting amendments to your record, to us at the following address:

Clever Care Health Plan
Attn: Privacy Officer
7711 Center Ave., Suite 100
Huntington Beach, CA 92647

Alternatively, you may submit your request by email to: compliance@ccmapd.com

Filing a Complaint.

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If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above. **You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We are prohibited by law from retaliating against you in any way for filing a complaint. Your decision to file a complaint will not affect your benefits or the care you receive.

Financial Information Privacy Notice

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Clever Care is committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, “personal financial information” means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect non-public personal financial information about you from the following sources:

- Information received from your application or other forms, such as name, address, age, medical information, and Social Security number.
- Information about your transactions with us, our affiliates, or others, such as premium payment and claims history.
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to non-affiliated third parties, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions, including but not limited to:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.
- To non-affiliated companies for our everyday business purposes, such as processing your transactions, maintaining your account(s), or responding to court orders and legal investigations.
- To non-affiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

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We maintain physical, electronic, and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or contact Member Services toll-free at 1-833-388-8168 (TTY: 711): October 1 to March 31: 8 am to 8 pm, 7 days a week and April 1 to September 30: 8 am to 8 pm, Monday through Friday

Section 1.4 We must give you information about our plan, our network of providers, and your covered services

As a member of Clever Care Breathe+, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Member Services at 1-833-388-8168 (TTY users call 711):

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know your treatment options and participate in decisions about your care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they are covered by our

CHAPTER 8 Your rights and responsibilities

plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. If you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what is to be done if you cannot able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

Legal documents that you can use to give directions in advance in these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill out the form and sign it.** No matter of where you get this form, it is a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you signed an advance directive, **take a copy with you to the hospital.**

- The hospital will whether you signed an advance directive form and whether you have it with you.
- If you did not sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

Filling out an advance directive is your choice (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

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If your instructions are not followed

If you sign an advance directive and you believe that a doctor or hospital did not follow the instructions in it, you can file a complaint with the California Department of Health.

Section 1.6 You have the right to make complaints and ask us to reconsider decisions we made

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

Section 1.7 If you believe you are being treated unfairly, or your rights are not being respected

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY users call 1-800-537-7697), or call your local Office for Civil Rights.

If you believe you have been treated unfairly or your rights have not been respected, *and it's not* about discrimination, you can get help dealing with the problem you are having from these places:

- **Call Member Services at 1-833-388-8168 (TTY users call 711).**
- **Call the SHIP at 1-800-434-0022.**
- **Contact Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048).**

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call our plan's Member Services at 1-833-388-8168 (TTY users call 711)**
- **Call your local SHIP at 1-800-434-0022.**
- **Contact Medicare**
 - Visit <https://www.Medicare.gov> to read the publication *Medicare Rights & Protections* (available at: www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf.)
 - Call 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048).

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Member Services at 1-833-388-8168 (TTY users call 711).

CHAPTER 8 Your rights and responsibilities

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what is covered and the rules you need to follow to get covered services.
 - Chapters 3 and 4 give details about medical services.
 - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show our plan membership card whenever you get medical care or Part D drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
 - Make sure your doctors know all the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - You must continue to pay a premium for your Medicare Part B to stay a member of our plan.
 - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
 - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your drug coverage.
 - If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you cannot stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 9: *If you have a problem or complaint (coverage decisions, appeals, complaints)*

CHAPTER 9:***If you have a problem or complaint (coverage decisions, appeals, complaints)*****SECTION 1 What to do if you have a problem or concern**

This chapter explains 2 types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints** (also called grievances).

Both processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it is sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. You should always call Member Services at 1-833-388-8168 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who is not connected with us. Two organizations that can help you are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. SHIP contact information is available in Chapter 2, Section 3.

CHAPTER 9: If you have a problem or complaint (coverage decisions, appeals, complaints)

Medicare

You can also contact Medicare for help.

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Visit www.medicare.gov.

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they are covered, and problems related to payment for medical care.

Yes.

Go to **Section 4, A guide to coverage decisions and appeals.**

No.

Go to **Section 10, How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems about your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we will cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think you need.

CHAPTER 9: If you have a problem or complaint (coverage decisions, appeals, complaints)

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but is not legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what is covered for you and how much we pay. In some cases, we might decide medical care is not covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you are not satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but is not legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go to a Level 2 appeal conducted by an independent review organization not connected to us.

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- Go to **Section 5.4** for more information about Level 2 appeals for medical care.
- Part D appeals are discussed further in Section 6.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call us at Member Services at 1-833-388-8168 (TTY users call 711)**
- **Get free help** from your State Health Insurance Assistance Program

CHAPTER 9: If you have a problem or complaint (coverage decisions, appeals, complaints)

- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at 1-833-388-8168 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at clevercarehealthplan.com.
 - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
 - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
 - If you want a friend, relative, or other person to be your representative, call Member Services at 1-833-388-8168 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at clevercarehealthplan.com.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
 - We can accept an appeal request from a representative without the form, but we cannot complete our review until we get it. If we do not get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations:

- **Section 5:** Medical care: How to ask for a coverage decision or make an appeal
- **Section 6:** Part D drugs: How to ask for a coverage decision or make an appeal
- **Section 7:** How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon
- **Section 8:** How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you are not sure which information applies to you, call Member Services at 1-833-388-8168 (TTY users call 711). You can also get help or information from your SHIP.

CHAPTER 9: *If you have a problem or complaint (coverage decisions, appeals, complaints)*

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we will explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the 5 following situations:

1. You are not getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we have said we will not pay for this care. **Make an appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 7 and 8. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:
A coverage decision that involves your medical care is called an organization determination .
A fast coverage decision is called an expedited determination .

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

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- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services you already got).
- You can get a fast coverage decision *only* if using the standard deadlines could cause serious harm to your health or hurt your ability to regain function.

If your doctor tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.

If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision. If we do not approve a fast coverage decision, we will send you a letter that:

- Explains that we will use the standard deadlines
- Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision
- Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we will give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to your prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we will give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we will give you an answer within 72 hours after we get your request.

- **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we *should not* take extra days, you can file a fast complaint. We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 10 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we will answer within 24 hours.

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- **However**, if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we should *not* take extra days, you can file a *fast complaint*. (Go to Section 10 for information on complaints.) We will call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we will send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 5.3 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration**.

A fast appeal is also called an **expedited reconsideration**.

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we will give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from

CHAPTER 9: If you have a problem or complaint (coverage decisions, appeals, complaints)

contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.

- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We are allowed to charge a fee for copying and sending this information to you.

Step 3: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all the information. We check to see if we followed all the rules when we said no to your request.
- We will gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires us to.
 - If you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Part B drug.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we will automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you did not get yet, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
 - If you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
 - If you believe we should not take extra days, you can file a fast complaint. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (Go to Section 10 of this chapter for information on complaints.)
 - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent

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review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal**, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 The Level 2 appeal process

Legal Terms:

The formal name for the independent review organization is the **Independent Review Entity**. It is sometimes called the **IRE**.

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We are allowed to charge a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information about your appeal.

If you had a fast appeal at Level 1, you will also have a fast appeal at Level 2.

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

If you had a standard appeal at Level 1, you will also have a standard appeal at Level 2.

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to**

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14 more calendar days. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

Step 2: The independent review organization gives you its answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we get the decision from the independent review organization for standard requests. For expedited requests, we have 72 hours from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug,** we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we get the decision from the independent review organization.
- **If this organization says no to part or all of your appeal,** it means it agrees with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:
 - Explains the decision
 - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
 - Tells you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 If you are asking us to pay for our share of a bill you got for medical care

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

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Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is a covered. We will also check to see if you followed the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we will send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we will send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you are asking us to pay you back for medical care you already got and paid for, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

SECTION 6 Part D drugs: How to ask for a coverage decision or make an appeal

Section 6.1 What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term Drug List instead of *List of Covered Drugs* or formulary.

- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

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Part D coverage decisions and appeals

Legal Terms:
An initial coverage decision about your Part D drugs is called a coverage determination .

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on our plan's Drug List. **Ask for an exception. Section 6.2**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

If you disagree with a coverage decision we made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to ask for an appeal.

Section 6.2 Asking for an exception

Legal Terms:
Asking for coverage of a drug that is not on the Drug List is a formulary exception .
Asking for removal of a restriction on coverage for a drug is a formulary exception .
Asking to pay a lower price for a covered non-preferred drug is a tiering exception .

If a drug is not covered in the way you would like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 2 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that is not on our Drug List.** If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to all our drugs. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost-sharing amount we require you to pay for the drug.

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- 3. Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you pay as your share of the cost of the drug.
- If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
 - If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing. This would be the lowest tier that contains biological product alternatives for treating your condition.
 - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
 - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
 - You cannot ask us to change the cost-sharing tier for any drug in Tier 5.
 - If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons you are asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List typically includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you are asking for and would not cause more side effects or other health problems, we generally would not approve your request for an exception. If you ask us for a tiering exception, we generally would not approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of our plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

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Section 6.4 How to ask for a coverage decision, including an exception**Legal Terms:**

A fast coverage decision is called an **expedited coverage determination**.

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

Standard coverage decisions are made within **72 hours** after we get your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. To get a fast coverage decision, you must meet 2 requirements:

- You must be asking for a drug you did not get yet. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
 - Explains that we will use the standard deadlines.
 - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
 - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We will answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form* or on our plan's form, which is available on our website clevercarehealthplan.com. Chapter 2 has contact information. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

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You, your doctor (or other prescriber), or your representative can do this. You can also have a lawyer act on your behalf. Section 4 tells how you can give written permission to someone else to act as your representative.

- **If you asking for an exception, provide the supporting statement** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and give you our answer.

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we get your request.
 - For exceptions, we will give you our answer within 24 hours after we get your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you did not get yet

- We must generally give you our answer **within 72 hours** after we get your request.
 - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we get your request.

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- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we are also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 6.5 How to make a Level 1 Appeal

Legal Terms:
An appeal to our plan about a Part D drug coverage decision is called a plan redetermination .
A fast appeal is called an expedited redetermination .

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you are appealing a decision we made about a drug you did not get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request** or call us. Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at 1-833-388-8168.** Chapter 2 has contact information.
- **We must accept any written request**, including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website clevercarehealthplan.com. Include your name, contact information, and information about your claim to help us process your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your

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appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.

- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

Step 3: We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires us to.
 - If we do not give you an answer within 72 hours, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you asked for**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you did not get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We will give you our decision sooner if you did not get the drug yet and your health condition requires us to do so.
 - If we do not give you a decision within 7 calendar days, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request.

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- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we are also required to make payment to you within **30 calendar** days after we get your request.
- **If our answer is no to part or all of what you asked for**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 6.6 How to make a Level 2 appeal

Legal Term:
The formal name for the independent review organization is the Independent Review Entity . It is sometimes called the IRE .

The independent review organization is an independent organization hired by Medicare. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.
 - **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we will automatically forward your request to the IRE.
- We will send the information about your appeal to the independent review organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

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Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all the information about your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you did not get yet. If you are requesting that we pay you back for a drug you already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

Step 3: The independent review organization gives you its answer.***For fast appeals:***

- **If the independent review organization says yes to part or all of what you asked for**, we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we get the decision from the independent review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage**, we must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

What if the independent review organization says no to your appeal?

If this organization says no to **part or all** of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It is also called **turning down your appeal**). In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you are asking for meets a certain minimum. If the dollar value of the drug coverage you are asking for is too low, you cannot make another appeal and the decision at Level 2 is final.

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- Tells you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go on to Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon

When you are admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They will help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay, and your request will be considered.

Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Member Services at 1-833-388-8168 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048).

1. Read this notice carefully and ask questions if you don't understand it. It tells you:

- Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about the quality of your hospital care.

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- Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we will cover your hospital care for a longer time.
2. **You will be asked to sign the written notice to show that you got it and understand your rights.**
 - You or someone who is acting on your behalf will be asked to sign the notice.
 - Signing the notice shows *only* that you got the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.
 3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.
 - If you sign the notice more than 2 calendar days before your discharge date, you will get another copy before you are scheduled to be discharged.
 - To look at a copy of this notice in advance, call Member Services at 1-833-388-8168 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also get the notice online at <https://www.cms.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im>.

Section 7.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-833-388-8168 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

CHAPTER 9: If you have a problem or complaint (coverage decisions, appeals, complaints)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
 - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
 - **If you do not meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at 1-833-388-8168 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). (TTY users should call 1-877-486-2048.) Or you can get a sample notice online at <https://www.CMS.gov/Medicare/forms-notice/beneficiary-notice-initiative/ffs-ma-im>.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary**.
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

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- If the independent review organization says *no*, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you are going on to *Level 2* of the appeals process.

Section 7.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information about your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you it's decision.

If the independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

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- It means they agree with the decision they made on your Level 1 appeal. This is called upholding the decision.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you are getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the 3 types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision.** This section tells you how to ask for an appeal.

Section 8.1 We will tell you in advance when your coverage will be ending

Legal Term:
Notice of Medicare Non-Coverage. It tells you how you can ask for a fast-track appeal . Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

1. You get a notice in writing at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:

- The date when we will stop covering the care for you.

CHAPTER 9: If you have a problem or complaint (coverage decisions, appeals, complaints)

- How to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got.** Signing the notice shows *only* that you have got the information about when your coverage will stop. **Signing it does not mean you agree** with our plan's decision to stop care.

Section 8.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-833-388-8168 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal.

It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the *Notice of Medicare Non-coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

CHAPTER 9: If you have a problem or complaint (coverage decisions, appeals, complaints)

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term:
Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you it's decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 8.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing

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facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information about your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you its decision.

What happens if the independent review organization says yes?

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3, 4, and 5

Section 9.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

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If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may or may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
 - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may or may not* be over.**
 - If you decide to accept the decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may or may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
 - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may or may not* be over.**
 - If we decide to accept this decision that turns down your appeal, the appeals process is over.

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- If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 9.2 Appeal Levels 3, 4, and 5 for Part D Drug Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal

An Administrative Law Judge or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
 - If you decide to accept the decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**

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- If you decide to accept the decision that turns down your appeal, the appeals process is over.
- If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Making Complaints

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems about quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or shared confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you are being encouraged to leave our plan?

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Complaint	Example
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan? ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all about the <i>timeliness</i> of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a <i>fast coverage decision</i> or a <i>fast appeal</i>, and we said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 10.2 How to make a complaint

Legal Terms
• A Complaint is also called a grievance. • Making a complaint is called filing a grievance. • Using the process for complaints is called using the process for filing a grievance. • A fast complaint is called an expedited grievance.

Step 1: Contact us promptly – either by phone or in writing.

- **Calling Member Services at 1-833-388-8168 (TTY users call 711) is usually the first step.** If there is anything else you need to do, Member Services will let you know.
- **If you do not want to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

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- We will address your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.
- An expedited grievance can be filed concerning a plan decision not to conduct a fast response to a coverage decision or appeal, or, if we take an extension on a coverage decision or appeal. We must respond to your expedited grievance within 24 hours.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint.** If you have a fast complaint, it means we will give you **an answer within 24 hours**.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 10.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.
Or
- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 10.4 You can also tell Medicare about your complaint

You can submit a complaint about Clever Care Breathe+ directly to Medicare. To submit a complaint to Medicare, go to <https://www.Medicare.gov/my/medicare-complaint>. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 10:

Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in Clever Care Breathe+ may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs, and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Open Enrollment Period

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Open Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
 - Another Medicare health plan, with or without drug coverage,
 - Original Medicare *with* a separate Medicare drug plan, or
 - Original Medicare *without* a separate Medicare drug plan.
 - If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Note: If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

CHAPTER 10: *Ending membership in our plan*

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
 - Switch to another Medicare Advantage Plan with or without drug coverage.
 - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Clever Care Breathe+ may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples. For the full list you can contact our plan, call Medicare, or visit www.Medicare.gov.

- Usually, when you move
- If you have Medi-Cal
- If you are eligible for Extra Help paying for Medicare drug coverage
- If we violate our contract with you
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital

Note: If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 9 tells you more about drug management programs.

Enrollment time periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

CHAPTER 10: Ending membership in our plan

- Another Medicare health plan with or without drug coverage,
- Original Medicare *with* a separate Medicare drug plan, or
- Original Medicare *without* a separate Medicare drug plan.

Note: If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will usually end** on the first day of the month after we get your request to change our plan.
- **If you get Extra Help from Medicare to pay your drugs coverage costs:** If you switch to Original Medicare and do not enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Section 2.4 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Member Services at 1-833-388-8168 (TTY users call 711).**
- Find the information in the *Medicare & You 2026* handbook.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

SECTION 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You will automatically be disenrolled from Clever Care Breathe+ when your new plan's coverage starts.
Original Medicare <i>with</i> a separate Medicare drug plan.	• Enroll in the new Medicare drug plan. • You will automatically be disenrolled from Clever Care Breathe+ when your new drug plan's coverage starts.

CHAPTER 10: Ending membership in our plan

To switch from our plan to:	Here's what to do:
Original Medicare <i>without</i> a separate Medicare drug plan.	• Send us a written request to disenroll. Call Member Services at 1-833-388-8168 (TTY users call 711) if you need more information on how to do this. • You can also call Medicare at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from Clever Care Breathe+ when your coverage in Original Medicare starts.

SECTION 4 **Until your membership ends, you must keep getting your medical items, services, and drugs through our plan**

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical services, items, and prescription drugs through our plan.

- **Continue to use our network providers to get medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you are hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage starts).

SECTION 5 **Clever Care Breathe+ must end our plan membership in certain situations**

Clever Care Breathe+ must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you move out of our service area
- If you are away from our service area for more than 6 months.
 - If you move or take a long trip, call Member Services at 1-833-388-8168 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area.
- You do not meet our plan's special eligibility requirements.
 - You must be diagnosed with a cardiovascular disorder, chronic heart failure or diabetes. In addition, your PCP must verify the diagnosis with the Plan.

CHAPTER 10: *Ending membership in our plan*

- If you become incarcerated (go to prison)
- If you are no longer a United States citizen or lawfully present in the United States
- If you lie or withhold information about other insurance, you have that provides prescription drug coverage
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose drug coverage.

If you have questions or want more information on when we can end your membership, call Member Services at 1-833-388-8168 (TTY users call 711).

Section 5.1 We cannot ask you to leave our plan for any health-related reason, unless you no longer have a medical condition required for enrollment in Clever Care Breathe+

In most cases, Clever Care Breathe+ cannot ask you to leave our plan for any health-related reason. The only time we are allowed to do this is if you no longer have the medical condition required for enrollment in Clever Care Breathe+.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 11

Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage Plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at <https://www.hhs.gov/ocr/index.html>.

If you have a disability and need help with access to care, call us at Member Services at 1-833-388-8168 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Clever Care Breathe+, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

CHAPTER 11 Legal notices

SECTION 4 Overpayment Recovery

We reserve the right to recover any overpayment made for health care services from anyone who receives such an overpayment or from any person or organization obligated to pay for the services. Recovery may be pursued from the individual, provider, or entity that received the overpayment or organization legally responsible for payment of those services. All recovery efforts will be conducted in accordance with applicable law.

SECTION 5 Reporting Fraud, Waste and Abuse

You Can Help Prevent Fraud Health Care.

The National Health Care Anti-Fraud Association estimates that the financial losses from health care fraud are about \$100 million per day. You can help Clever Care Health Plan, Inc. OR us to prevent, detect, and correct health care fraud by reporting any suspicious activity. When you report a situation that may be potential health care fraud, you're doing your part to help save money for the health care system.

What is Health Care Fraud, Waste and Abuse?

Fraud occurs when someone knowingly and willfully submits a false claim that results in inappropriate payments.

Examples: Billing for services not rendered, falsifying a patient's diagnosis to justify unnecessary procedures, or accepting kickbacks for patient referrals.

Waste is overuse of services or other practices that, directly or indirectly, results in unnecessary medical costs. This includes the misuse of resources which is not generally considered a criminally negligent action.

Examples: Ordering excessive diagnostic tests, overuse of office visits, or a pharmacy sending medications to members without confirming they still need them.

Abuse is an action that may result in unnecessary medical costs. When a person or entity unknowingly or purposely misrepresents fact to obtain payment, this is abuse.

Examples: Charging in excess for services or supplies, providing medically unnecessary services, or going to different doctors or emergency rooms to obtain pain medication.

Protect yourself and your benefits

- Never give out your Social Security, Medicare, or health plan numbers or banking information to someone you don't know or trust.
- Do not consent to any lab tests without your doctor's order
- It is illegal to accept anything of value in exchange for medical services.

Be aware of genetic testing fraud

Scammers approach unsuspecting enrollees at health fairs, senior housing facilities and other trustworthy locations to carry out genetic testing fraud. They falsely promise that Medicare

CHAPTER 11 Legal notices

will pay the test and all you need to do is provide a cheek swab, identification and Medicare information in order to receive your test results.

If you fall victim to a scam involving unauthorized genetic testing, fraudulent actors may gain access to your personal and genetic information which can be used to bill Medicare thousands of dollars for a service you never received.

Report Potential Fraud, Waste and Abuse (FWA)

Clever Care provides you various ways to report potential FWA issues. For more information on how to report, visit our website, clevercarehealthplan.com.

SECTION 6 Notice about Manifest MedEx to Help Coordinate Important Health Information

Clever Care Health Plan, Inc. has partnered with Manifest MedEx (MX), a nonprofit health information exchange (HIE) to help physicians, hospitals, and other health care providers coordinate and share important health information when treating our members.

MX combines information from different healthcare providers in one place so treating providers can quickly access the information they need to make better decisions about your care.

As a member, you are automatically enrolled in the program. However, you may “opt-out” if you do not want to make your health information available to other providers. By opting out of MX, you are choosing not to have your health records accessible by your healthcare team through the MX system, including your primary care provider and Clever Care nurse care manager. Opting out of MX with one provider means your information will not be shared with any provider, even in the case of an emergency.

You have three ways to opt-out of participation:

- Call Manifest MedEx support at 1 (800) 490-7617
- Go online and complete MX’s online form at: <https://www.manifestmedex.org/opt-out>
- Complete and scan a form available at: <https://www.manifestmedex.org/opt-out-2/>

Your choice to participate or not (opt-out) will not affect your ability to access medical care; however, we hope you will participate and enjoy the benefits of more coordinated care.

CHAPTER 12 *Definitions*

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already got. You may also make an appeal if you disagree with our decision to stop services that you are getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of Clever Care Breathe+, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing our plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not gotten any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

Biological Product - A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. (go to “**Original Biological Product**” and “**Biosimilar**”).

Biosimilar - A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (go to “**Interchangeable Biosimilar**”).

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent \$2,100 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

CHAPTER 12 Definitions

Chronic-Care Special Needs Plan (C-SNP) – C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs after you pay any deductibles.

Complaint - The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example \$10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are gotten. (This is in addition to our plan's monthly premium.) Cost sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services or drugs are covered; 2) any fixed copayment amount that a plan requires when a specific service or drug is gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is gotten.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all the prescription drugs covered by our plan.

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around,

CHAPTER 12 Definitions

and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one-month's supply in our plan is 30 days, then your daily cost-sharing rate is \$1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Disenroll or Disenrollment – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the person's eligibility.

Dual Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you are asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you are asking for (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

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Generic Drug – A prescription drug that is approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you are still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Institutional Special Needs Plan (I-SNP) – I-SNPs restrict enrollment to MA eligible people who live in the community but need the level of care a facility offers, or who live (or are expected to live) for at least 90 days straight in certain long-term facilities. I-SNPs include the following types of plans: Institutional-equivalent SNPs (IE-SNPs) Hybrid Institutional SNPs (HI-SNPs), and Facility-based Institutional SNPs (FI-SNPs).

Institutional Equivalent Special Needs Plan (IE-SNP) – An IE-SNP restricts enrollment to MA eligible people who live in the community but need the level of care a facility offers.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (formulary or Drug List) – A list of prescription drugs covered by our plan.

CHAPTER 12 Definitions

Low Income Subsidy (LIS) – Go to Extra Help.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

Maximum Out-of-Pocket Amount – The most that you pay out of pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for our plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. In addition to the maximum out-of-pocket amount for in-network covered Part A and Part B medical services, we also have a maximum out-of-pocket amount for certain types of services.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term

CHAPTER 12 Definitions

Medicare-Covered Services does not include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill gaps in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying

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doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs gotten is also referred to as the member's out-of-pocket cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventative services – Health care to prevent illness or detect illness at an early state, when treatment is likely to work best (for example, preventative services include Pap tests, flu shots, and screening mammograms).

Primary Care Physician (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services and/or certain drugs based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

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Prosthetics and Orthotics – Medical devices including, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that is designed to limit the use of a drug for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

"Real-Time Benefit Tool" - A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Referral - A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may or may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plan or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting Extra Help with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

Standard Cost Sharing – Standard cost sharing is cost sharing other than preferred cost sharing offered at a network pharmacy.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

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Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside our plan's service area, or it is unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) are not considered urgently needed even if you are outside our plan's service area or our plan network is temporarily unavailable.

Clever Care Breathe+ Member Services

Method	Member Services – Contact Information
CALL	1-833-388-8168 Calls to this number are free. October 1st through March 31st 8 am to 8 pm, seven days a week; April 1st through September 30th 8 am to 8 pm, Monday through Friday Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. October 1st through March 31st 8 am to 8 pm, seven days a week; April 1st through September 30th 8 am to 8 pm, Monday through Friday
FAX	1-657-276-4720
WRITE	Clever Care Health Plan 7711 Center Ave., Suite 100 Huntington Beach, CA 92647
WEBSITE	clevercarehealthplan.com

Health Insurance Counseling & Advocacy Program (HICAP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1-800-434-0022
WRITE	California Department of Aging 1300 National Drive, Suite 200 Sacramento, CA 95834-1992
WEBSITE	aging.ca.gov/hicap

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



Non-Discrimination and Accessibility Requirements

Discrimination is Against the Law

Clever Care Health Plan Inc. (herein referred to as Clever Care) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Clever Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Clever Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, please call (833) 388-8168 (TTY: 711).

If you believe that Clever Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:

Clever Care Health Plan
Attn: Civil Rights Coordinator
7711 Center Ave
Suite 100
Huntington Beach CA 92647

E-mail: civilrightscoordinator@ccmapd.com

Fax: (657) 276-4721

You can file a grievance by mail, fax, or email. If you need help filing a grievance, our Clever Care Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



Notice Of Availability

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-833-388-8168 (TTY: 711) or speak to your provider. **Español:** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-833-388-8168 (TTY: 711) o hable con su proveedor. **Tagalog:** PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-833-388-8168 (TTY: 711) o makipag-usap sa iyong provider. **中文:** 注意: 如果您说[中文], 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。致电 1-833-808-8153 (国语) / 1-833-808-8161 (粤语) (TTY: 711) 或咨询您的服务提供商。 **台語:** 注意: 如果您說[台語], 我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務, 以無障礙格式提供資訊。請致電 1-833-808-8153 (國語) / 1-833-808-8161 (粵語) (TTY: 711) 或與您的提供者討論。 **Việt:** LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-833-808-8163 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn. **한국어:** 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-833-808-8164 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오. **ՀԱՅԵՐԵՆ:** ՈՒՇԱԿՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, Դուք կարող եք օգտվել լեզվական աջակցության անվճար ծառայություններից: Մատչելի ձևաչափերով տեղեկատվություն տրամադրվելու համապատասխան օժանդակ միջոցներն ու ծառայությունները նույնպես տրամադրվում են անվճար: **മലയാളം:** 1-833-388-8168 നോക്കുക (TTY: 711) കൂടുതൽ വിവരങ്ങൾക്ക്. **РУССКИЙ:** ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-833-388-8168 (TTY: 711) или обратитесь к своему поставщику услуг. **ភាសាខ្មែរ:** សូមយកចិត្តទុកដាក់: ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសា ឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដល់អ្នក ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបាន ដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ 1-833-388-8168 (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវាបំប៉នអ្នក។ **日本語:** 注: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-833-388-8168 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。 **ਪੰਜਾਬੀ:** ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਟਰਾਂਸਕ੍ਰਿਪਟ ਵਿੱਚ ਸਾਹਾਇਕ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 1-833-388-8168 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ। **ไทย:** หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-833-388-8168 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ **Lus Hmoob:** LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-833-388-8168 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

فارسی

توجه: اگر فارسی صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-833-388-8168 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

العربية

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-833-388-8168 (TTY: 711) أو تحدث إلى مقدم الخدمة.

