



# 20**26** Summary of Benefits

## **Clever Care Total+ (HMO C-SNP)**

**A Medicare Advantage and Prescription Drug Plan**

### **Serving California**

Los Angeles, Orange, San Bernardino, Riverside, and San Diego counties

**Plan Year: January 1, 2026 – December 31, 2026**

**TOTAL+**

The benefit information provided is a summary of medical and prescription drug costs. A complete list of the services, limitations, and exclusions is found in the Evidence of Coverage (EOC) at [clevercarehealthplan.com/eoc](https://clevercarehealthplan.com/eoc).

**To join this Clever Care HMO C-SNP plan, you must be:**

- 1. entitled to Medicare Part A
- 2. enrolled in Medicare Part B
- 3. diagnosed with diabetes mellitus, chronic heart failure (CHF), or a qualifying cardiovascular disorder<sup>1</sup>
- 4. living in our service area:
  - Los Angeles
  - Orange
  - San Bernardino
  - Riverside
  - San Diego



**Find network doctors, specialists, hospitals, and pharmacies.** If you go to an out-of-network provider, you will be responsible for the full cost of services.

[clevercarehealthplan.com/provider](https://clevercarehealthplan.com/provider)



**Look up medications on the Formulary (list of drugs).**

[clevercarehealthplan.com/formulary](https://clevercarehealthplan.com/formulary)



If you need help understanding this information, call us at **1-833-388-8168 (TTY:711)** 8 am to 8 pm, seven days a week, from October 1 to March 31; and 8 am to 8 pm, weekdays, from April 1 to September 30. Or send an email to [sales@clevercarehealthplan.com](mailto:sales@clevercarehealthplan.com).

If you want to know more about the coverage and costs of Original Medicare, look in your current *Medicare & You* handbook. View it online at [medicare.gov](https://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

<sup>1</sup> This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying condition. Not all members qualify.



## 2026 Summary of Benefits | Clever Care Total+ (HMO C-SNP)

A holistic plan for individuals diagnosed with a cardiovascular disorder, chronic heart failure, or diabetes and receive Medi-Cal.

**You will see this  if reduced cost-sharing applies.**

If you are enrolled in the full Medi-Cal program, you pay nothing for medical services. If you have Medi-Cal and share of cost (SOC), the plan premium, deductible, and any cost-sharing will be paid in full or part by Medi-Cal or a third party. You must remain enrolled in Medi-Cal for reduced cost-sharing.

### Premiums, Deductibles, and Limits

| Costs                                                                        | With Full Medi-Cal You Pay | Without Medi-Cal You Pay | Important to Know                                                                                                                                                                   |
|------------------------------------------------------------------------------|----------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Monthly Plan Premium</b><br>(Part C & Part D)                             | \$0                        | \$0                      | You must continue to pay your Medicare Part B premium.                                                                                                                              |
| <b>Deductible</b>                                                            | \$0                        | \$615                    |  This plan has deductibles for some hospital and medical services and Part D prescription drugs. |
| <b>Maximum Out-of-Pocket Responsibility</b><br>(excludes prescription drugs) | \$0 annually               | \$9,250 annually         |  This is the most you will pay annually for covered Medicare services.                           |

### Medical & Hospital Benefits

| Benefits                                                                                                                                     | With Full Medi-Cal You Pay                                                                                    | Without Medi-Cal You Pay                                                                                                                                                                                                                                                                   | Important to Know                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| <b>Inpatient Hospital Coverage*</b>                                                                                                          | \$0 copay per benefit period                                                                                  | The following Medicare defined amounts are for 2026. <ul style="list-style-type: none"><li>\$1,736 deductible per benefit period</li><li>\$0 copay per day for days 1–60, per benefit period and days 91 and more</li><li>\$434 copay per day for days 61–90, per benefit period</li></ul> |  |
| <b>Outpatient Hospital Coverage*</b> <ul style="list-style-type: none"><li>Outpatient hospitalization</li><li>Observation services</li></ul> | <ul style="list-style-type: none"><li>\$0 copay per stay</li><li>\$0 copay for observation services</li></ul> | <ul style="list-style-type: none"><li>20% coinsurance per stay</li><li>20% coinsurance for observation services</li></ul>                                                                                                                                                                  |  |

\*Service requires a referral and/or prior authorization.

TOTAL+

| Benefits                                                                                                                                                                                                                                          | With Full Medi-Cal You Pay                                                                                              | Without Medi-Cal You Pay                                                                                                                  | Important to Know                                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Ambulatory Surgical Center (ASC) Services*</b>                                                                                                                                                                                                 | \$0 copay per visit                                                                                                     | 20% coinsurance per visit                                                                                                                 |                                                                        |
| <b>Doctor Visits</b> <ul style="list-style-type: none"> <li>Primary care physician (PCP)</li> <li>Specialist*</li> </ul>                                                                                                                          | \$0 copay per visit<br>\$0 copay per specialist visit                                                                   | \$0 copay per visit<br>\$0 copay per specialist visit                                                                                     |                                                                                                                                                           |
| <b>Preventive Care</b> <ul style="list-style-type: none"> <li>Welcome to Medicare visit or Annual wellness visit and all other preventive care services covered by Medicare</li> </ul>                                                            | \$0 copay per visit                                                                                                     | \$0 copay per visit                                                                                                                       | One wellness visit per year. The purpose of this visit is to create a personalized prevention plan based on your current health and risk factors.         |
| <b>Emergency Care</b> <ul style="list-style-type: none"> <li>Emergency room</li> </ul>                                                                                                                                                            | \$0 per visit                                                                                                           | \$95 copay per visit                                                                                                                      |  The copay is \$0 if you are admitted to the hospital within 72 hours. |
| <b>Urgently Needed Services</b> <ul style="list-style-type: none"> <li>Urgent Care Center</li> </ul>                                                                                                                                              | \$0 copay per visit                                                                                                     | \$25 copay per visit                                                                                                                      |                                                                        |
| <b>Diagnostic Services, Labs, and Imaging*</b> <ul style="list-style-type: none"> <li>Lab services</li> <li>Diagnostic tests, procedures</li> <li>X-rays</li> <li>Diagnostic radiology services (e.g. MRIs, CT scans, PET scans, etc.)</li> </ul> | \$0 copay per lab service<br>\$0 copay per diagnostic service<br>\$0 copay per X-ray<br>\$0 copay per radiology service | 20% coinsurance per lab service<br>\$0 copay per diagnostic service<br>20% coinsurance per X-ray<br>20% coinsurance per radiology service |                                                                       |

\*Service requires a referral and/or prior authorization.

| Benefits                                                                                                                                                                                                                                                                                                                                                                                           | With Full Medi-Cal You Pay                                                                                          | Without Medi-Cal You Pay                                                                         | Important to Know                                                                                                                                                                                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Hearing Services*</b> <ul style="list-style-type: none"> <li>Medicare covered services</li> </ul>                                                                                                                                                                                                                                                                                               | \$0 copay per service                                                                                               | \$0 copay per service                                                                            | You must use a doctor in our network for routine services.                                                                                                                                                                                                                          |
| <b>Hearing Services (routine)</b> <ul style="list-style-type: none"> <li>Routine hearing exam (limit 1)</li> <li>Hearing aid fitting and evaluation (limit 3)</li> <li>Hearing aids</li> </ul> <p>This plan provides an <b>allowance of \$600</b> per ear, per year for hearing aids.</p>                                                                                                          | \$0 copay per exam or service<br>\$0 copay per exam or service<br>\$0 copay up to the maximum plan allowance amount | \$0 copay per exam<br>\$0 copay per service<br>\$0 copay up to the maximum plan allowance amount | Any unused allowance will expire December 31.<br><br>After plan-paid benefits, you are responsible for the remaining cost and may use the flexible allowance as a form of payment.<br><br>A deductible applies for a one-time replacement of lost, stolen, or damaged hearing aids. |
| <b>Dental Services*</b> <ul style="list-style-type: none"> <li>Medicare covered services</li> </ul>                                                                                                                                                                                                                                                                                                | \$0 copay per service                                                                                               | \$0 copay per service                                                                            | There is no requirement to stay in-network. Limitations and exclusions apply for certain dental services. Prior authorization is required for implants and other services.                                                                                                          |
| <b>Dental Services (PPO)</b><br><b>Preventive dental services include:</b> <ul style="list-style-type: none"> <li>Oral exam (limit 2)</li> <li>Dental cleanings (limit 2)</li> <li>Fluoride treatment (limit 1)</li> <li>Bitewing X-ray (limit 2)</li> </ul>                                                                                                                                       | \$0 copay up to the maximum plan allowance amount for preventive and/or comprehensive services                      | \$0 copay up to the maximum plan allowance amount for preventive and/or comprehensive services   | 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.                                                                                                                           |
| <b>Comprehensive dental services include, but not limited to:</b> <ul style="list-style-type: none"> <li>Fillings and repairs</li> <li>Root canals</li> <li>Dental crowns</li> <li>Implants</li> <li>Bridges, dentures, extractions</li> </ul> <p>This plan provides a <b>bi-annual allowance of \$1,200</b> for preventive and comprehensive services. The maximum annual benefit is \$2,400.</p> |                                                                                                                     |                                                                                                  | After plan-paid benefits, you are responsible for the remaining cost and may use the flexible allowance as a form of payment.<br><br>Any unused allowance will roll over to the next six-month period and expire December 31.<br><br>Excludes orthodontia.                          |

\*Service requires a referral and/or prior authorization.



| Benefits                                                                                                                            | With Full Medi-Cal You Pay                                      | Without Medi-Cal You Pay                                                                                                                                                                                                              | Important to Know                                                                                                                                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Skilled Nursing Facility (SNF)*</b>                                                                                              | \$0 copay per stay                                              | The following Medicare defined amounts are for 2026. <ul style="list-style-type: none"> <li>\$0 copay, per day, for days 1–20 of each benefit period</li> <li>\$217 copay, per day, for days 21–100 of each benefit period</li> </ul> |  <p>No prior hospitalization is required.</p>                                                                           |
| <b>Physical Therapy*</b> <ul style="list-style-type: none"> <li>Occupational, physical, and speech and language</li> </ul>          | \$0 copay per visit                                             | 20% coinsurance per visit                                                                                                                                                                                                             |                                                                                                                         |
| <b>Ambulance</b> <ul style="list-style-type: none"> <li>Ground transport</li> <li>Air transport</li> </ul>                          | \$0 coinsurance per trip (each way)<br>\$0 coinsurance per trip | 20% coinsurance per trip (each way)<br>20% coinsurance per trip                                                                                                                                                                       |                                                                                                                         |
| <b>Transportation</b><br>This plan provides <b>48 one-way</b> non-emergency rides.                                                  | \$0 copay per trip                                              | \$0 copay per trip                                                                                                                                                                                                                    | Rides to an approved health-related location are limited to a 30-mile radius.                                                                                                                              |
| <b>Medicare Part B Drugs</b> <ul style="list-style-type: none"> <li>Insulin</li> <li>Chemotherapy and other Part B drugs</li> </ul> | \$0 copay<br>\$0 copay                                          | 0–20% coinsurance of the cost or the Medicare-allowed amount, not to exceed \$35<br>0–20% coinsurance of the cost or the Medicare-allowed amount                                                                                      |  <p>Prices may change on a quarterly basis, but cost sharing will not exceed 20% coinsurance or \$35 for insulin.</p> |

\*Service requires a referral and/or prior authorization.

Wellness benefits included in your plan

| Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | With Full Medi-Cal<br>You Pay                                                                                                                                                                                                | Without Medi-Cal<br>You Pay                                                                                                                                                                                                  | Important to Know                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
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| <b>Health and Wellness Flex Allowance</b><br><br>This plan provides a <b>combined quarterly allowance of \$600</b> . The annual maximum benefit is \$2,400.<br><br><b>Fitness activities</b> include, but are not limited to: <ul style="list-style-type: none"><li>• Golf, table tennis</li><li>• Tai Chi, yoga</li><li>• Gym membership</li></ul><br><b>Over-the-Counter Items (OTC)</b> include, but are not limited to: <ul style="list-style-type: none"><li>• Pain medication</li><li>• Cold &amp; flu medicine</li><li>• First aid supplies</li></ul><br><b>Herbal Supplements</b> include, but are not limited to: <ul style="list-style-type: none"><li>• Ginseng</li><li>• Bird's Nest</li><li>• Tiger balm</li></ul><br><b>Dental, Vision and/or Hearing</b> expenses beyond the annual allowance.<br><br><b>Groceries (healthy food and produce)*</b> only if an eligible chronic condition is verified by the Plan and your PCP. Refer to the Special Supplemental Benefits for the Chronically Ill. | <br><br>\$0 copay up to the maximum plan allowance amount, per quarter.<br><br><b>You choose</b> how to spend the allowance from the list of eligible services.<br><br>Pay for services using the Flex Benefits MasterCard®. | <br><br>\$0 copay up to the maximum plan allowance amount, per quarter.<br><br><b>You choose</b> how to spend the allowance from the list of eligible services.<br><br>Pay for services using the Flex Benefits MasterCard®. | <br><br>After plan-paid benefits, you are responsible for the remaining costs. Allowance may not be exchanged for cash.<br><br>Any unused allowance will roll over to the next 3 months (quarter); and expire December 31.<br><br>You can purchase OTC items online and at retail locations.<br><br>Herbal supplements can be purchased from a network supplier or by calling Member Services.<br><br>Grocery purchases are allowed only if an eligible chronic condition is verified by your PCP. This benefit is limited to healthy food and produce and excludes tobacco and alcohol and other restricted items. |

TOTAL+

\*Service requires a referral and/or prior authorization.



| Benefits                                                                                                                                                                                                                                                         | With Full Medi-Cal You Pay                                                        | Without Medi-Cal You Pay                                                          | Important to Know                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Acupuncture Services (routine)</b><br>This plan covers unlimited in-network, routine acupuncture services up to <b>\$2,000 every year</b> .                                                                                                                   | \$0 copay, per visit, up to the plan maximum amount                               | \$0 copay, per visit, up to the plan maximum amount                               | No referral or prior authorization required.<br><br>You must use a doctor in our network for routine services.                                                                     |
| <b>Eastern Wellness Services</b><br>This plan offers a maximum of <b>24</b> wellness services per calendar year. Services include: <ul style="list-style-type: none"> <li>• Cupping/Moxa</li> <li>• Tui Na, Gua Sha</li> <li>• Med-X, and Reflexology</li> </ul> | \$0 copay, per visit, up to the maximum allowed visits                            | \$0 copay, per visit, up to the maximum allowed visits                            | After plan-paid benefits, you are responsible for the remaining costs. The annual plan maximum will not carry over to the next plan year.                                          |
| <b>Health and Wellness (routine)</b> <ul style="list-style-type: none"> <li>• Annual physical exam</li> </ul>                                                                                                                                                    | \$0 copay for one visit per year                                                  | \$0 copay for one visit per year                                                  | This exam is more extensive than the annual wellness visit. It involves the doctor feeling or listening to or tapping areas of the body, in addition to bloodwork and other tests. |
| <b>Telehealth Visit</b><br>Visits can take place using your phone, tablet, or computer. <ul style="list-style-type: none"> <li>• Teladoc® visit (available 24-hours a day).</li> <li>• Visit offered through your doctor's office.</li> </ul>                    | \$0 copay for a medical or mental health Teladoc visit<br><br>\$0 copay per visit | \$0 copay for a medical or mental health Teladoc visit<br><br>\$0 copay per visit | Teladoc providers can diagnose and treat non-emergent conditions and prescribe medications when necessary.                                                                         |

More benefits included in your plan

| Benefits                                                                                                                                                                                                                                                                                                                                             | You Pay                                                                                                                                                                                                                                                                                                                                                                                                                  | Important to Know                                                                                                                                                                                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Worldwide Coverage</b><br>This plan has an annual limit of <b>\$100,000</b> for covered emergency care, urgently needed services, and ambulance rides outside the United States and its territories.                                                                                                                                              | \$0 copay per service                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                         |
| <b>Post-discharge Healing at Home*</b><br>This plan offers a combined benefit to help with recovery immediately following an inpatient hospital or a skilled nursing facility stay. You will receive: <ul style="list-style-type: none"><li>• Personal care coordination</li><li>• Home delivered meals</li><li>• In-home support services</li></ul> | Personal follow-up calls from a case manager within 72 hours to help with medication review and education, and other support as needed.<br><br>\$0 copay for meal assistance up to 3 meals per day for 28 days; not to exceed 84 meals per year.<br><br>\$0 copay to receive up to 60 hours of help per year. Includes assistance with daily living activities, transportation to appointments, grocery store, and more. | Not available after an outpatient procedure.<br><br>Members must call Member Services within 7 days of discharge and request authorization.<br><br>This benefit can be in addition to, but not a replacement of, Medicare-covered home health services. |
| <b>Personal Emergency Response System (PERS)*</b><br>This is a mobile device and monitoring service to connect you with a 24-hour response center.                                                                                                                                                                                                   | \$0 copay for one device per year                                                                                                                                                                                                                                                                                                                                                                                        | Call Member Services.                                                                                                                                                                                                                                   |

TOTAL+

\*Service requires a referral and/or prior authorization.

| Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | You Pay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Important to Know                                                                                                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Special Supplemental Benefits for the Chronically Ill (SSBCI)*</b><br><p>If you are diagnosed with a chronic condition listed below and meet certain criteria, you may be eligible for additional benefits. Diagnosis limitations apply.</p> <ul style="list-style-type: none"> <li>• Autoimmune disorders</li> <li>• Cancer</li> <li>• Cardiovascular disorders</li> <li>• Chronic alcohol or drug dependency</li> <li>• Chronic and disabling mental health conditions</li> <li>• Chronic gastrointestinal disease</li> <li>• Chronic heart failure</li> <li>• Chronic kidney disease</li> <li>• Chronic lung disorders</li> <li>• Conditions associated with cognitive impairment</li> <li>• Dementia</li> <li>• Diabetes mellitus</li> <li>• HIV/AIDS</li> <li>• Immunodeficiency and immunosuppressive disorders</li> <li>• Neurologic disorders</li> <li>• Post-organ transplant care</li> <li>• Severe hematologic disorders</li> <li>• Stroke</li> </ul> | <b>Healthy Food &amp; Produce (Grocery)</b><br><p>After approval by the Plan, the flexible allowance will be made available to purchase approved healthy food and produce items.</p><br><b>Meals for Chronic Conditions</b><br><p>\$0 copay for meal assistance up to 3 meals a day for 14 days; not to exceed 42 meals per year for members who qualify.</p><br><b>Telemonitoring Service</b><br><p>\$0 copay for a device to monitor medical and other health data.</p><br><b>In-home Safety Assessment</b><br><p>\$0 copay for up to 2 assessments per year.</p><br><b>In-home Support Services</b><br><p>\$0 copay for services to assist with activities of daily living. Limited to 40 hours per year.</p><br><b>Social Needs Benefits</b><br><p>\$0 copay for companionship services by non-clinical personal caregivers. Services are limited to 24 4-hour shifts (96 total hours).</p><br><b>Support for Caregivers</b><br><p>\$0 copay for respite care. Limited to 40 hours per year.</p> | <p>The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify.</p><br><p>Confirmation of a qualifying condition from your PCP and prior authorization by the Plan are required before these benefits may be used.</p><br><p>Services will be provided using the plan's contracted vendors.</p> |

\*Service requires a referral and/or prior authorization.

# Rx Prescription Drug Coverage

Clever Care Total+ (HMO C-SNP)

Your cost-sharing may differ depending on the pharmacy you choose (e.g., standard retail, out-of-network, mail-order) or whether you receive a 30- or 100-day supply. If you live in a long-term care facility (LTC), you pay the same amount as you would at a standard retail pharmacy for a 31-day supply of medication. If you have Medi-Cal and share of cost, the Part D deductible and coinsurance will be paid in full or part by Medi-Cal or a third party. You must remain enrolled in Medi-Cal for reduced cost-sharing.

## Part D prescription drug benefit and what you pay.

|                                                                                                                                                      |                                                                                                                                                                  |                          |                                          |                       |                                                         |                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|------------------------------------------|-----------------------|---------------------------------------------------------|----------------------|
| <b>Stage 1:<br/>Annual Deductible</b>                                                                                                                | <b>\$615</b><br>This annual deductible does not apply to Tiers 1, 6, or insulin drugs.                                                                           |                          |                                          |                       |                                                         |                      |
| <b>Stage 2:<br/>Initial Coverage</b><br>You pay the following until your maximum out-of-pocket reaches \$2,100.                                      | <b>Retail Standard Cost-sharing (In-network)</b>                                                                                                                 |                          | <b>Mail-order Standard Cost-sharing</b>  |                       | <b>Retail Cost-sharing (Out-of-network)<sup>2</sup></b> |                      |
|                                                                                                                                                      | <b>30-100 day supply with Full Medi-Cal</b>                                                                                                                      | <b>30-100 day supply</b> | <b>100 day Supply with Full Medi-Cal</b> | <b>100 day supply</b> | <b>30-day supply with Full Medi-Cal</b>                 | <b>30-day supply</b> |
| <b>Tier 1:<br/>Preferred Generic</b>                                                                                                                 | \$0 copay                                                                                                                                                        | \$0 copay                | \$0 copay                                | \$0 copay             | \$0 copay                                               | \$0 copay            |
| <b>Tier 2:<br/>Generic</b>                                                                                                                           | \$0 copay                                                                                                                                                        | 10% coinsurance          | \$0 copay                                | 10% coinsurance       | \$0 copay                                               | 10% coinsurance      |
| <b>Tier 3:<br/>Preferred Brand</b>                                                                                                                   | \$0 copay                                                                                                                                                        | 25% coinsurance          | \$0 copay                                | 25% coinsurance       | \$0 copay                                               | 25% coinsurance      |
| <b>Tier 4:<br/>Non-Preferred Brand</b>                                                                                                               | \$0 copay                                                                                                                                                        | 25% coinsurance          | \$0 copay                                | 25% coinsurance       | \$0 copay                                               | 25% coinsurance      |
| <b>Tier 5:<br/>Specialty Tier<sup>2</sup></b>                                                                                                        | \$0 copay                                                                                                                                                        | 25% coinsurance          | \$0 copay                                | 25% coinsurance       | \$0 copay                                               | 25% coinsurance      |
| <b>Tier 6:<br/>Select Care Drugs<sup>3</sup></b>                                                                                                     | \$0 copay                                                                                                                                                        |                          | \$0 copay                                |                       | \$0 copay                                               |                      |
| <b>Insulin:</b>                                                                                                                                      | You will not pay a deductible or more than \$35 per month for a supply of each covered insulin product regardless of the cost-sharing tier.                      |                          |                                          |                       |                                                         |                      |
| <b>Vaccines:</b>                                                                                                                                     | You will not pay a deductible or a copay for Advisory Committee on Immunization Practices (ACIP) recommended adult vaccines regardless of the cost-sharing tier. |                          |                                          |                       |                                                         |                      |
| <b>Stage 3:<br/>Catastrophic Coverage</b><br>After the total yearly maximum \$2,100, you will stay in this stage until the end of the calendar year. | During this payment stage, you pay \$0 for covered Part D drugs.                                                                                                 |                          |                                          |                       |                                                         |                      |

<sup>2</sup> A long term supply of medication is not available at out-of-network pharmacies or for Tier 5 Specialty drugs.

<sup>3</sup> Tier 6 Select Care Drugs includes preferred generic Stars drugs used to treat diabetes, blood pressure, and cholesterol. It also includes excluded drugs (prescription cough medicine, vitamins and generic Viagra).



# Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, please call and speak to a customer service representative at 1-833-388-8168 (TTY:711), 8 am to 8 pm, seven days a week, from October 1 to March 31; and 8 am to 8 pm, weekdays, from April 1 to September 30.

## Understanding the benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [clevercarehealthplan.com/eoc](https://clevercarehealthplan.com/eoc) or call 1-833-388-8168 (TTY:711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

## Understanding important rules

- ☐ **For plans with a monthly premium:** In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ **For plans with a zero premium:** You do not pay a separate monthly plan premium for this plan, but you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1 of each year.
- ☐ **For HMO plans only:** Except in an emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ **For C-SNP plans only:** This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.
- ☐ **Effect on Current Coverage:** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

Clever Care Health Plan, Inc. is an HMO and HMO C-SNP with a Medicare contract. Enrollment depends on contract renewal. Our provider and pharmacy network may change at any time. We protect your privacy. Refer to the Notice of Privacy Practices: [clevercarehealthplan.com/privacy](https://clevercarehealthplan.com/privacy). All trademarks are the sole property of their respective owners. The Benefits Mastercard® Prepaid Card is issued by The Bancorp Bank N.A. ©2025 NationsBenefits, LLC. All rights reserved. NationsBenefits is a registered trademark of NationsBenefits, LLC.

M11128-SB-TLP-EN (12/25)