Clever Care
HEALTH PLAN

2026 Summary of Benefits

VALUE

Clever Care Value (HMO)

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

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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.

To join this Clever Care HMO plan, you must be:

1. entitled to Medicare Part A
2. enrolled in Medicare Part B
3. living in our service area:
   - Los Angeles
   - Orange
   - San Bernardino
   - Riverside
   - San Diego

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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

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

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.

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 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.

2026 Summary of Benefits

Clever Care Value (HMO) | An essential plan with a $120 Part B premium reduction.

Premiums, Deductibles, and Limits

Costs	You Pay	Important to Know
Monthly Plan Premium (Part C & Part D)	$0	You must continue to pay your Medicare Part B premium.
Part B Premium Reduction	The difference between the $120 paid by the plan and the Part B premium amount.	This is not a reimbursement. You must pay the reduced Part B premium amount. If your Part B premium comes out of your Social Security check, the reduced amount will be reflected in your monthly check.
Deductible	$0	
Maximum Out-of-Pocket Responsibility (excludes prescription drugs)	$2,000 annually	This is the most you will pay annually for covered Medicare services.

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Medical & Hospital Benefits

Benefits	You Pay	Important to Know
Inpatient Hospital Coverage*	$100 copay per day, for days 1–5; $0 copay per day, for days 6–90, per benefit period	Covered for unlimited days.
Outpatient Hospital Coverage*		
• Outpatient hospitalization	$75 copay per stay	
• Observation services	$0 copay for observation services	
Ambulatory Surgical Center (ASC) Services*	$75 copay per visit	
Doctor Visits		
• Primary care physician (PCP)	$0 copay per visit	
• Specialist*	$0 copay per specialist visit	
Preventive Care • Welcome to Medicare visit or Annual wellness visit and all other preventive care services covered by Medicare	$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.
Emergency Care		
• Emergency room	$125 copay per visit	The copay is $0 if you are admitted to the hospital within 72 hours.
Urgently Needed Services		
• Urgent Care Center	$0 copay per visit	

*Service requires a referral and/or prior authorization.

Benefits	You Pay	Important to Know
Diagnostic Services, Labs, and Imaging*		
• Lab services • Diagnostic tests, procedures • X-rays • Diagnostic radiology services (e.g. MRIs, CT scans, PET scans, etc.)	$0 copay per lab service $0 copay per service $0 copay per X-ray $75 copay per service	
Hearing Services*		You must use a doctor in our network for routine services.
• Medicare covered services	$0 copay per service	
Hearing Services (routine)		Any unused allowance will expire December 31.
• Routine exam (limit 1) • Hearing aid fitting and evaluation (limit 3) • Hearing aids	$0 copay per exam $0 copay per service $0 copay up to the maximum plan allowance amount	After plan-paid benefits, you are responsible for the remaining cost and may use the flexible allowance as a form of payment.
This plan provides an **allowance of $600** per ear, per year for hearing aids.		A deductible applies for a one-time replacement of lost, stolen, or damaged hearing aids.
Dental Services*		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.
• Medicare covered services	$0 copay per service	
Dental Services (PPO)*		
Preventive dental services include: • Oral exam (limit 2) • Dental cleanings (limit 2) • Fluoride treatment (limit 1) • Bitewing X-ray (limit 2)	$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. After plan-paid benefits, you are responsible for the remaining cost and may use the flexible allowance as a form of payment.
Comprehensive dental services include, but not limited to: • Fillings and repairs • Root canals • Dental crowns • Implants • Bridges, dentures, extractions		Any unused allowance will roll over to the next six-month period and expire December 31. Excludes orthodontia.
This plan provides a **biannual allowance of $400** for preventive and comprehensive services. The maximum annual benefit is $800.		

*Service requires a referral and/or prior authorization.

Benefits	You Pay	Important to Know
Vision Services*		You must use a doctor in our network for routine services. If you go to an out-of-network provider, you pay the full cost. After plan-paid benefits, you are responsible for the remaining cost and may use the flexible allowance as a form of payment. Any allowance amount not used will expire December 31.
• Medicare-covered vision exam to diagnose/treat diseases and conditions of the eye	$0 copay per exam	
• Medicare-covered glasses after cataract surgery	$0 copay per item	
Vision Services (routine)		
• Routine eye exam	$0 copay per exam	
• Eyewear (frames, lenses, or contacts) • Upgrades	$0 copay up to the maximum plan allowance amount.	
This plan provides an **annual allowance of $200** for eyewear.		
Mental Health Services*		The inpatient care lifetime limit does apply to mental health services provided in a general hospital.
• Inpatient hospital - psychiatric	$175 copay per day for days 1–7; $0 copay per day for days 8–90, per benefit period	
• Outpatient mental health care (group or individual therapy)	$25 copay per visit	
Skilled Nursing Facility (SNF)*	$0 copay per day for days 1–20; $210 copay per day for days 21–100, per benefit period	No prior hospitalization is required.
Physical Therapy*		
• Occupational, physical, and speech and language	$5 copay per visit	
Ambulance		
• Ground transport	$150 copay per trip (each way)	
• Air transport	20% coinsurance per trip	
Transportation This plan provides **16 one-way** non-emergency rides.	$0 copay per trip	Rides to an approved health-related location are limited to a 30-mile radius.
Medicare Part B Drugs*		Prices may change on a quarterly basis, but cost sharing will not exceed 20% coinsurance or $35 for insulin.
• Insulin	0–20% coinsurance of the cost or the Medicare-allowed amount, not to exceed $35	
• Chemotherapy and other Part B drugs	0–20% coinsurance of the cost or the Medicare-allowed amount	

*Service requires a referral and/or prior authorization.

Wellness benefits included in your plan

Benefits	You Pay	Important to Know
Health and Wellness Flex Allowance This plan provides a **combined quarterly allowance of $90.** The annual maximum benefit is $360. **Fitness activities** include, but are not limited to: • Golf, table tennis • Tai Chi, yoga • Gym membership **Over-the-Counter Items (OTC)** include, but are not limited to: • Pain medication • Cold & flu medicine • First aid supplies **Herbal Supplements** include, but are not limited to: • Ginseng • Bird's Nest • Tiger balm **Dental, Vision and/or Hearing** expenses beyond the annual allowance. **Groceries** (healthy food and produce)* only if an eligible chronic condition is verified by the Plan and your PCP. Refer to the Special Supplemental Benefits for the Chronically Ill.	$0 copay up to the maximum plan allowance amount, per quarter. **You choose** how to spend the allowance from the list of eligible services. Pay for services using the Flex Benefits MasterCard®.	After plan-paid benefits, you are responsible for the remaining costs. Allowance may not be exchanged for cash. Any unused allowance will roll over to the next 3 months (quarter); and expire December 31. You can purchase OTC items online and at retail locations. Herbal supplements can be purchased from a network supplier or by calling Member Services. 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.
Acupuncture Services (routine) This plan covers unlimited in-network, routine acupuncture services up to **$1,000 every year**. **Eastern Wellness Services** This plan offers a maximum of **12** wellness services per calendar year. Services include: • Cupping/Moxa • Tui Na, Gua Sha • Med-X, and Reflexology	$0 copay, per visit, up to the plan maximum amount $0 copay, per visit, up to the maximum allowed visits	No referral or prior authorization required. You must use a doctor in our network for routine services. After plan-paid benefits, you are responsible for the remaining costs. The annual plan maximum will not carry over to the next plan year.

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Benefits	You Pay	Important to Know
Health and Wellness (routine) • Annual physical exam	$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 blood work and other tests.
Telehealth Visit Visits can take place using your phone, tablet, or computer. • Teladoc® visit (available 24-hours a day). • Visit offered through your doctor's office.	$0 copay for medical or mental health visit $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
Worldwide Coverage This plan has an annual limit of **$75,000** for covered emergency care, urgently needed services, and ambulance rides outside the United States and its territories.	$0 copay per service	
Post-discharge Healing at Home* This plan offers a combined benefit to help with recovery immediately following an inpatient hospital or a skilled nursing facility stay. You will receive: • Personal care coordination • Home delivered meals • In-home support services	Personal follow-up calls from a case manager within 72 hours to help with medication review and education, and other support as needed. $0 copay for meal assistance up to 3 meals a day for 28 days; not to exceed 84 meals per year. $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. Members must call Member Services within 7 days of discharge and request authorization. This benefit can be in addition to, but not a replacement of Medicare-covered home health services.
Personal Emergency Response System (PERS)* 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.

*Service requires a referral and/or prior authorization.

Benefits	You Pay	Important to Know
Special Supplemental Benefits for the Chronically Ill (SSBCI)*	**Healthy Food & Produce (Grocery)**	The benefit mentioned is part of a special supplemental program for the chronically ill. Not all members qualify.
If you are diagnosed with a chronic condition listed below and meet certain criteria, you may be eligible for additional benefits. Diagnosis limitations apply. • 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	After approval by the Plan, the flexible allowance will be made available to purchase approved healthy food and produce items.	Confirmation of a qualifying condition from your PCP and prior authorization by the Plan are required before these benefits may be used. Services will be provided using the Plan's contracted vendors.

*Service requires a referral and/or prior authorization.

Rx Prescription Drug Coverage
Clever Care Value (HMO)

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.

Part D prescription drug benefit and what you pay.				
Stage 1: **Annual Deductible**	**$0** This stage does not apply because there is no deductible.			
Stage 2: **Initial Coverage** You pay the following until the total yearly drug cost reaches $2,100.	**Retail Standard Cost-sharing (In-network)**		**Mail-order Standard Cost-sharing**	**Retail Cost-sharing (Out-of-network)**[1]
	30-day supply	**100-day supply**	**100-day supply**	**30-day supply**
Tier 1: **Preferred Generic**	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2: **Generic**	$0 copay	$0 copay	$0 copay	$0 copay
Tier 3: **Preferred Brand**	$30 copay	$90 copay	$60 copay	$30 copay
Tier 4: **Non-Preferred Brand**	$75 copay	$225 copay	$150 copay	$75 copay
Tier 5: **Specialty Tier**[1]	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
Tier 6: **Select Care Drugs**[2]	$0 copay	$0 copay	$0 copay	$0 copay
Insulin:	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.			
Vaccines:	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.			
Stage 3: **Catastrophic Coverage** 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.			

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[1] A long term supply of medication is not available at out-of-network pharmacies or for Tier 5 Specialty drugs.

[2] 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 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.

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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.