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Clever Care HEALTH PLAN

2023
Summary of Benefits

Clever Care Fortune Medicare Advantage (HMO)

A Medicare Advantage and Prescription Drug Plan

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

Plan Year: January 1, 2023 – December 31, 2023

H7607_23_ CM1308_ FTN _M Accepted 09042022

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A Clever Care Medicare Advantage HMO plan gives you the convenience of having medical services, prescription drug coverage, Eastern treatments, dental coverage, and more covered through one plan.

To join you must be entitled to Medicare Part A, be enrolled Medicare Part B, and live in one county of our service area: **Los Angeles, Orange, San Bernardino, Riverside, or San Diego.**

Our network of doctors, hospitals, pharmacies, drug list and more can be found on our website:

Primary care physicians and other providers	clevercarehealthplan.com/provider
Pharmacies	clevercarehealthplan.com/pharmacy
Formulary (list of covered drugs)	clevercarehealthplan.com/formulary

If you need help understanding this information, please call us at **1-833-388-8168 (TTY:711):**

October 1 – March 31
8 a.m. to 8 p.m., 7 days a week.
April 1 – September 30
8 a.m. to 8 p.m., Monday through Friday.

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, 7 days a week. TTY users should call 1-877-486-2048.

2023 Summary of Benefits

CLEVER CARE FORTUNE MEDICARE ADVANTAGE (HMO)

A plan with an enhanced fitness benefit and a low MOOP.

Below is a summary of medical and prescription drug costs. A complete list of the services we cover is in the Evidence of Coverage (EOC). **The EOC is available on our website October 15.**

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.
Deductible	$0	
Maximum out-of-pocket responsibility (does not include Part D prescription drugs.)	$1,000 annually	This is the most you would pay, for the year, for covered Medicare services.

MEDICAL & HOSPITAL BENEFITS

Benefits	You Pay	Important to Know
Inpatient hospital care	$150 copay per day for days 1–5 $0 copay per day for days 6–90	**Services may require prior authorization.** If you go to an out-of-network provider, you pay the full cost. This plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient hospital and surgery services • Outpatient hospital facility • Ambulatory surgical center • Observation services	 $100 copay per visit $75 copay per visit $100 copay for observation services	**Services may require prior authorization.** If you go to an out-of-network provider, you pay the full cost.
Doctor Visits • Primary care physician (PCP) • Specialist	 $0 copay per visit $0 copay per visit	**A Prior Authorization is not required for your first appointment with a specialist.** You will need a Prior Authorization for any follow-up visits or future services. If you go to an out-of-network provider, you pay the full cost.
Preventive care • Welcome to Medicare visit • Annual wellness visit	$0 copay for one visit per year	Any additional preventive services approved by Medicare during the contract year will be covered.

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Benefits	You Pay	Important to Know
Emergency care	$90 copay per visit to an emergency room	The copay is waived if you are admitted to the hospital within 72 hours for the same condition.
Urgently needed services	$20 copay per visit to an urgent care center	The copay is waived if you are admitted to the hospital within 72 hours for the same condition.
Diagnostic services, labs, and imaging		**Services may require Prior Authorization.**
• Lab services	$0 copay	Covered according to Medicare guidelines.
• Diagnostic tests, procedures, and basic radiology	$0 copay	
• Outpatient X-rays	$0 copay for outpatient X-rays	If you go to an out-of-network provider, you pay the full cost.
• Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.)	$175 copay for each CT, MRI and PET Scan	
	$0 copay for all other diagnostic radiology	
• Therapeutic radiology services (such as radiation treatment for cancer)	20% coinsurance of the Medicare-allowed amount for each therapeutic radiology service	While you pay 20% for therapeutic radiology services, you will never pay more than your total out-of-pocket maximum for the year.
Hearing services		You must use a doctor in our hearing network.
• Diagnostic hearing exam	$0 copay for each Medicare-covered visit.	
Hearing services (non-Medicare covered, routine)		Hearing aids are available through **NationsHearing** and limited to specific devices based on your hearing needs.
• Routine hearing exam	$0 copay for one routine hearing exam.	
• Hearing aid fitting and Evaluation	$0 copay for up to 3 fitting and evaluations per year.	After plan-paid benefits for routine hearing exams or hearing aids, you are responsible for the remaining cost.
• Hearing aids	$0 copay for hearing aids up to the maximum plan benefit amount. This plan covers up to **$500** per ear for hearing aids every year.	A deductible applies for a one-time replacement for lost, stolen or damaged hearing aids.

Benefits	You Pay	Important to Know
Dental services (routine) • Medicare covered services Preventive dental services include: • Dental cleanings (limit 2 per year) • Oral exam (limit 2 per year) • Fluoride treatment (limit 1 per year) • X-ray (limit 1 per year) Additional covered comprehensive dental services include, but are not limited to: • Deep teeth cleaning • Fillings and repairs • Root canals (Endodontics) • Dental crowns (Caps) • Bridges, Dentures, Extractions and other services	$0 copay for each Medicare-covered service This plan provides an **allowance of $375** up to four times a year, starting on your effective date. The annual maximum benefit is $1,500. $0 copay, up to the allowance amount for preventive and comprehensive dental services. Excludes surgical placement of dental implants.	**Pre-treatment authorizations are required for restorative crowns and fixed prosthodontics.** **There is no requirement to stay in-network.** However, your out-of-pocket costs may be lower when using a Liberty Dental network provider. Any amount not used by March 31, June 30, or September 30, will roll over, and expire December 31. After plan-paid benefits for dental services, you are responsible for the remaining costs. You may be responsible for the difference between the allowed and billed amounts if utilizing an out-of-network provider.
Vision services • Medicare-covered vision exam to diagnose/treat diseases and conditions of the eye • Medicare-covered glasses after cataract surgery	$20 copay for each Medicare-covered visit $0 copay for diabetic retinopathy exam $0 copay for Medicare-covered glasses after cataract surgery	**Services may require Prior Authorization.**
Vision services (non-Medicare covered, routine) • Routine eye exam, including refraction • Eyewear (frames, lenses, or contacts)	$0 copay for one routine eye exam every calendar year. $0 copay for eyewear up to the plan allowance amount. This plan provides up to **$240** for eyewear every year.	You must use a doctor in the **EyeMed** network for non-Medicare covered services. If you go to an out-of-network provider, you pay the full cost. After plan-paid benefits for routine services, you are responsible for the remaining costs.

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Benefits	You Pay	Important to Know
Mental health services • Inpatient mental health care • Outpatient mental health care	$175 copay per day for days 1–7 $0 copay per day for days 8–90 20% coinsurance for outpatient group or individual therapy visit	**Services may require prior authorization.** The inpatient care lifetime limit does apply to mental health services provided in a general hospital. If you go to an out-of-network provider, you pay the full cost.
Skilled nursing facility (SNF)	$0 copay per day for days 1–20 $180 copay per day for days 21–100	**Services may require prior authorization.** No prior hospitalization is required. If you go to an out-of-network provider you pay the full cost.
Rehabilitation Services • Occupational therapy • Physical therapy and speech and language therapy • Cardiac rehabilitation • Pulmonary rehabilitation	$15 copay per visit $15 copay per visit $30 copay per visit $20 copay per visit	**Services may require prior authorization.** If you go to an out-of-network provider you pay the full cost.
Ambulance	$150 copay per trip (each way) for ground ambulance service. 20% coinsurance of the Medicare allowed amount for air ambulance transport services.	
Transportation	$0 copay for 28 one-way trips for non-emergency transportation within a 25-mile radius every year	
Medicare Part B Drugs	20% coinsurance of the Medicare-allowed amount for chemotherapy drugs 20% coinsurance of the Medicare-allowed amount for other Part B drugs	**Services may require prior authorization.** If you go to an out-of-network provider, you pay the full cost.

WELLNESS BENEFITS INCLUDED IN YOUR PLAN

Benefits	You Pay	Important to Know
Health and Wellness (Flexible spending allowance) **Fitness activities** include, but not limited to: • Golf • Gym membership • Tai Chi classes • Yoga or Pilates classes	$0 copay up to the allowance amount This plan provides an **allowance of $550** up to four times a year, starting on your effective date. The annual maximum benefit is $2,200. **You choose** how to spend the allowance. Pay for services using your flex debit card.	After plan-paid benefits, you are responsible for the remaining costs. Any amount not used by March 31, June 30, or September 30 will not carry over and expire December 31.
Acupuncture services This plan covers unlimited in-network acupuncture visits services up to $2,500 maximum. **Eastern wellness services** Services include: • Cupping/Moxa • Tui Na • Gua Sha • Med-X • Reflexology	$0 copay per visit up to the plan maximum This plan offers a maximum of **18 wellness services** per calendar year. $0 copay per visit up to the maximum allowed visits.	You must use a doctor in our acupuncture network. If you go to an out-of-network provider, you pay the full cost.
Health and Wellness (non-Medicare covered, routine service) • Annual physical exam by your PCP	$0 copay for one visit per year.	This service is not covered by Original Medicare. The annual physical exam usually includes the doctor feeling or listening to the body or tapping areas of the body.
24-hour Nurseline A registered nurse is available via phone 24 hours a day, seven days a week to address medical questions or concerns.	$0 copay	Use this benefit to get advice from a medical provider when you are not sure where to seek care or have questions about an urgent healthcare event.

Benefits	You Pay	Important to Know
Telehealth visit • Teladoc® visit • Video visit offered through your physician's office.	$0 copay for a medical visit 20% coinsurance for a mental health visit $0 copay	Teladoc physicians or mental health providers are available 24-hours a day for non-emergency health issues. Teladoc Physicians can diagnose and treat basic medical conditions, and they can also prescribe medications when medically necessary. These visits can take place using your phone, tablet, or computer.
COVID-19 services When diagnosed with COVID-19 the plan covers: • Testing • Treatment • Transportation • Mental health • Telemedicine • Prescription drug benefits	$0 copay	**Services may require prior authorization.** In cases of an emergency, care provided by both network and out-of-network providers will be covered.

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MORE BENEFITS INCLUDED IN YOUR PLAN:

Benefits	You Pay	Important to Know
Worldwide Coverage	$50,000 annual limit for covered emergency care, urgently needed services, and ambulance rides, outside the United States and its territories	
Medical equipment and supplies • Durable medical equipment • Prosthetics (e.g. braces, artificial limbs) • Diabetic therapeutic shoes and inserts • Diabetes self-management training, diabetic services, and supplies	0% coinsurance for items $500 or less. 20% coinsurance of the Medicare-allowed amount for items over $500 20% coinsurance of the Medicare-allowed amount You pay a $0 copay for diabetes self-management training, diabetic services, and supplies	**Services may require prior authorization.** If you go to an out-of-network provider, you pay the full cost. This plan covers one blood glucose monitor per year.

Benefits	You Pay	Important to Know
Post-discharge Meals Immediately following an inpatient hospital or a skilled nursing facility stay, this plan provides meal assistance for 28 days not to exceed 84 meals per year to help with recovery.	$0 copay up to the maximum allowed meals per year.	**Services may require prior authorization.** Not applicable after outpatient surgery.
Personal Emergency Response System (PERS) A mobile device and monitoring service to connect you with a 24-hour response center with the push of a button.	$0 copay for one device per year	**Services may require prior authorization.**
Foot Care (Podiatry) Medicare-covered foot care Foot Care (non-Medicare covered, routine)	 $0 copay for each Medicare-covered visit Not covered	**Services may require prior authorization.** If you go to an out-of-network provider, you pay the full cost.
Chiropractic services Medicare-covered chiropractic care	 $0 copay for each Medicare-covered visit	**Services may require prior authorization.** Medicare covers services to help correct subluxation of the spine. If you go to an out-of-network provider, you pay the full cost.

Benefits	You Pay	Important to Know
Special Supplemental Benefits for the Chronically Ill (SSBCI) These benefits are for eligible members who must participate in our Case Management Program and adhere to activities with defined goals and outcome measures. Members with one or more of the chronic conditions listed below may be eligible for these extra supplemental benefits. • Cardiovascular disorders • Dementia • Diabetes • End-stage liver disease • End-stage renal disease • HIV/AIDS • Chronic lung disorders • Chronic and disabling mental health conditions • Neurologic disorders • Stroke	**Meals for Chronic Conditions** $0 copay for 3 meals per day for 14 days not to exceed 42 meals per year. **Groceries** $0 copay for eligible food items with a $25 limit per month. Does not rollover to the following month. **Social Needs Benefits** $0 copay for companionship services rendered by non-clinical personal caregivers. Services are limited to 24, four-hour shifts (96 total hours). **At Home Wellness Check Visit** $0 copay for an at-home wellness check visit. **Telemonitoring Service** $0 copay for a device to monitor medical and other health data. **In-home Safety Assessment** $0 copay for up to two assessments per year. **In-home Support Services** $0 copay for services to assist with activities of daily living. **Support for Caregivers** $0 copay for respite care, limited to 40 hours of care giving per year.	**Services may require prior authorization.** All SSBCI benefits are for members who meet certain criteria and approval by the Plan. Services will be provided using the plan's contracted providers and/or vendors. The meal benefit is not available following an outpatient surgery visit. This service is limited to those meeting fall risk criteria, gait, balance, or agility challenges.

Prescription Drug Coverage

Effective January 1, 2023 through December 31, 2023

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 (paid by the plan and you) reaches $4,660.	**Standard retail cost-sharing (In-network)**		**Standard Cost-sharing (Mail Order)**	**Retail cost-sharing (Out-of-network)***
	30-day supply	**100-day supply**	**100-day supply**	**30-day supply**
Tier 1: Preferred Generic Drugs	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2: Generic Drugs	$0 copay	$0 copay	$0 copay	$0 copay
Tier 3: Preferred Brand Drugs	$35 copay	$105 copay	$70 copay	$35 copay
Tier 4: Non-Preferred Drugs	$99 copay	$297 copay	$198 copay	$99 copay
Tier 5: Specialty Tier Drugs	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
Tier 6: Supplemental Drugs**	$0 copay	$0 copay	$0 copay	$0 copay

* A long term, 100-day, supply of medication is not available at out-of-network pharmacies.
** Tier 6 supplemental drugs include generic Viagra, prescription cough medicine and vitamins.

Stage 3: Coverage Gap After the total yearly drug cost reaches $4,660 you remain in this stage until the total yearly drug cost (paid by the plan and you) reaches $7,400.	During this stage you pay: • $0 copay for a 30-day supply of Tier 1 preferred generic drugs. • $0 copay for a 30-day supply of Tier 2 generic drugs. • $35 copay for a 30-day supply of select Tier 3 preferred brand drugs. • 25% of the price for brand and specialty drugs (plus a portion of the dispensing fee).
Stage 4: Catastrophic Coverage After the total yearly drug cost reaches $7,400 you will stay in this stage until the end of the calendar year.	During this stage you pay the greater of: • 5% of the cost, or • $4.15 copay for a generic drug (including brand drugs treated as generic) or • $10.35 copay for all other drugs.

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Clever ways to save on your prescription drugs!

NEW FOR 2023! 100-DAY SUPPLY OF MEDICATIONS

Getting something for nothing is always nice. When your provider writes a 90-day prescription Clever Care will automatically authorize the prescription to be filled for 100 days. That's 10 days of medication at no extra cost to you!

PRESCRIPTION MAIL ORDER

This service is offered through Medimpact Direct and is for medication taken daily. When you sign up for the service you get the convenience of receiving an extended supply of medication (100-days) for the cost of two copayments instead of three; and prescriptions are delivered safely to you at no charge. Tier 5 drugs are eligible for this service but limited to a 30-day supply.

ZERO OR LOW COST FOR SELECT INSULINS

The Part D Senior Savings Model helps to keep the cost for insulin low during what is known as the "coverage gap". Depending on the brand of insulin taken, your out-of-pocket cost will be either $0 or $35 maximum for a 30-day supply in all coverage stages.

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Rewards Program for Healthy Activities

Participation in activities and screenings that focus on promoting improved health, prescription drug adherence, preventing injuries and illness, deserve to be rewarded. After approval, the reward amount will be added to your flex allowance card.

Reward dollars of up to $600 can be used to purchase grocery food, over the counter items and herbal supplements.

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 a.m. to 8 p.m., seven days a week, from October 1 through March 31, and 8 a.m. to 8 p.m., weekdays, from April 1 through September 30.

UNDERSTANDING THE BENEFITS

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor for. Visit **clevercarehealthplan.com** or call Customer Service at 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.

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 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.

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Clever Care Health Plan, Inc. is an HMO plan with a Medicare contract. Enrollment depends on contract renewal.

We protect your privacy. See the Evidence of Coverage or view our Notice of Privacy Practices on clevercarehealthplan.com/privacy to learn more.