Clever Care HEALTH PLAN

LONGEVITY

VALUE

TOTAL+

BREATHE+

2026 Enrollment Guide

Clever Care Medicare Advantage (HMO) and (HMO C-SNP) Plans

Longevity (HMO) | Value (HMO) | Total+ (HMO C-SNP) | Breathe+ (HMO C-SNP)
Los Angeles, Orange, San Bernardino, Riverside, and San Diego counties

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

Call to enroll now:
(833) 365-1888 (TTY: 711)

Current members:
(833) 388-8168 (TTY: 711)

October 1 – March 31
8 am to 8 pm, 7 days a week

April 1 – September 30
8 am to 8 pm, Monday through Friday

Visit our website at clevercarehealthplan.com

Language should never be a barrier to quality care.

Our HMO plans provide multilingual services to support you wherever you are in your health care journey. We also offer two Chronic Special Needs Plans (C-SNP) for diabetes, cardiovascular disorders, chronic heart failure and some chronic lung conditions.

Clever Care's unique blend of Western medicine and Eastern wellness covers all aspects of care while honoring your traditions and values.

This book provides all the information you need about Clever Care's Medicare Advantage plans and guides you through the enrollment process.

We look forward to welcoming you to the Clever Care family.



Karen Walker Johnson
Chief Executive Officer



Richard Greene
President

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Medicare Basics

There are two parts to **Original Medicare**, Part A (Hospital) and Part B (Medical). A **Medicare Advantage Plan** is also called Part C and combines all of the benefits of Original Medicare, plus extras like dental, vision, hearing, over-the-counter drugs and fitness, and in some cases Part D (Prescription Drugs).

A **Health Maintenance Organization (HMO)** is type of Medicare Advantage plan, known as a "managed care" plan. With an HMO, you choose a primary care physician (PCP) from a network of approved providers. All health care services, including referrals, are managed by your PCP. An HMO offers affordable, high-quality care with reduced premiums, fixed out-of-pocket copays or coinsurance amounts, and the safety net of an out-of-pocket maximum.

Original Medicare:

Part A (Hospital)



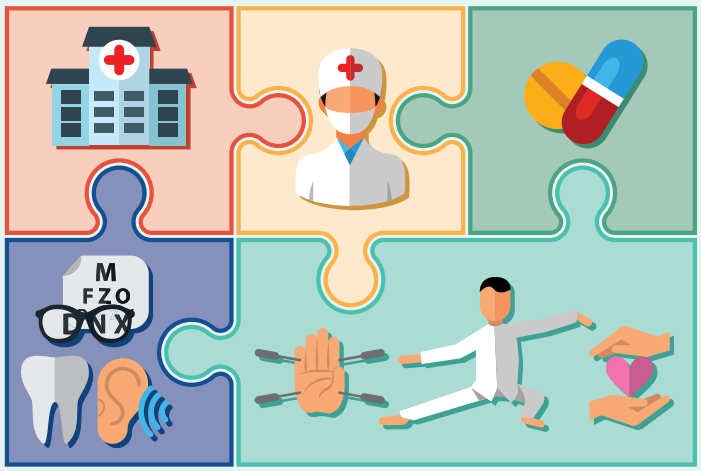
Part B (Medical)

VS.

Clever Care's Medicare Advantage (HMO) Plans:

Part B (Medical)

Part A (Hospital)



Part D (Prescription Drug)

Dental, Vision, and Hearing coverage

Eastern wellness, herbal supplements, OTC, and Fitness



Download our
Clever Guide to Medicare at **clevercarehealthplan.com/clever-guides**

About Clever Care

With over 15,000 providers, 50+ leading hospitals, and 2,500+ bilingual physicians and Eastern wellness specialists, Clever Care plans go beyond Original Medicare to provide a unique and affordable complete health care and wellness experience.

Clever Care HMO plans are the right choice for you if you want:

- Predictable costs ($0 deductible and $0 PCP copay)
- Trusted providers and hospitals in your community
- Convenience of a PCP managing your care
- Maximum out-of-pocket protection
- Prescription drug coverage
- Eastern wellness treatments (such as acupuncture, gua sha, cupping)
- Dental, vision, and hearing coverage
- In-language support from your health plan

Health + Wellness centered around you

In addition to benefits like prescription drugs, dental, vision, and hearing, Clever Care offers an array of culturally focused benefits, including:



- Access to 700+ acupuncturists, with **no referrals required**
- 800+ OTC and herbal supplement products
- Eastern wellness visits such as cupping, moxa, tui na, gua sha, and reflexology
- Fitness benefits that include gym memberships and activities like golf, tai chi, and yoga

Bringing the traditions of health and community together

We don't just acknowledge the communities we service; we actively participate in them. Clever Care has community centers that provide free in-language resources in Vietnamese, Korean, Mandarin and Cantonese communities through programs such as:



- Medicare Basics
- Member Orientation
- Doctor seminars
- Meditation and fitness activities
- Birthday celebrations
- Monthly cultural activities

We Have You Covered

Clever Care Medicare Advantage plans offer:

- Prescription drug coverage
- Allowance for herbal supplements
- Allowance for over-the-counter (OTC) items

It's easy to explore our covered products

Call our Member Services team toll free at (833)-388-8168 (TTY: 711). Our representatives are here to help in your spoken language.

For fast and up-to-date information, visit our website for drug lists and participating pharmacies.

Scan the QR codes below for our OTC and herbal supplement catalogs.

Prescription Drugs

Drug Formulary:

clevercarehealthplan.com/formulary

Participating Pharmacies:

clevercarehealthplan.com/pharmacy

OTC and Herbal Supplement

nations benefits

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Learn more about using your flex benefit card and fi d a few suggestions out of over 3,500 stores to shop.

Clever Care Plan Overview

	Longevity (HMO)	**Value** (HMO)	**Total+/Breathe+** (HMO C-SNP) with Full Medi-Cal[1]	**Total+/Breathe+** (HMO C-SNP) without Full Medi-Cal[1]
Monthly Premium	**$0**	**$0**	**$0**	**$0**
Part B Reduction	**N/A**	**$120**/month	**N/A**	**N/A**
Out of Pocket Max	**$500**	**$2,000**	**$0**	**$9,250**
PCP Visits	**$0**	**$0**	**$0**	**$0**
Specialist Visits	**$0**	**$0**	**$0**	**$0**
Dental (paid in bi-annual installments with rollover)	**$2,200** maximum	**$800** maximum	**$2,400** maximum	**$2,400** maximum
Acupuncture	**$2,000** maximum per year	**$1,000** maximum per year	**$2,000** maximum per year	**$2,000** maximum per year
Eastern Wellness	**24** Visits	**12** Visits	**24** Visits	**24** Visits
Flex Benefi [2]	**$1,260** maximum per year	**$360** maximum per year	**$2,400** maximum per year	**$2,400** maximum per year
Urgent Care	**$0**	**$0**	**$0**	**$25**
Choose this Option For	Extensive coverage including rich supplemental and Eastern wellness benefits for a **$0** monthly premium and **low out-of-pocket costs** for services.	Dependable coverage for a **$0** monthly plan premium and a monthly Medicare **Part B premium reduction** that puts money back in your pocket.	Must have an eligible chronic condition. **$0** plan premium, **$0** out-of-pocket costs on services if you are eligible for **full Medi-Cal**.	A holistic plan for people with diabetes or a cardiovascular disorder, or chronic heart failure (Total+) or asthma, chronic bronchitis, emphysema or COPD (Breathe+). **$0** plan premium.

This plan comparison is a high-level overview for your convenience. For information on these and other benefits, please reference the Summary of Benefits or ask your broker.

[1] This is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying chronic condition. Not all members qualify. If you have full Medi-Cal the cost of services will be paid in full by Medi-Cal or a third party. If you don't, the amount paid for services will vary. [2] Flexible benefit allowance can be used on OTC items, herbal supplements, fitness, or after maximum is reached on dental, vision, and hearing allowance. Members eligible for SSBCI can also use on **groceries**. If you have autoimmune disorders, cardiovascular disorders, chronic alcohol and other drug dependence, diabetes mellitus, severe hematologic disorders or another eligible chronic condition not listed here you may be eligible for a special supplemental program for the chronically ill. Not all members qualify. Other eligibility and coverage criteria apply. All Total+ and Breathe+ members are SSBCI eligible due to criteria needed to join these plans.

M10901-EGP-EN (10/25)

Clever Care
HEALTH PLAN

LONGEVITY

2026 Summary of Benefits

Clever Care Longevity (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

H7607_26_CM1308_M 09152025

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





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 Longevity (HMO) | Our flagship plan with comprehensive benefits.

LONGEVITY

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 (excludes prescription drugs)	$500 annually	This is the most you will pay annually for covered Medicare services.

Medical & Hospital Benefits

Benefi s	You Pay	Important to Know
Inpatient Hospital Coverage*	$0 copay per benefit period	Covered for unlimited days.
Outpatient Hospital Coverage*		
• Outpatient hospitalization	$0 copay per stay	
• Observation services	$0 copay for observation services	
Ambulatory Surgical Center (ASC) Services*	$0 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 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	$90 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	
Diagnostic Services, Labs, and Imaging*		
• Lab services	$0 copay per service	
• Diagnostic tests, procedures	$0 copay per service	
• X-rays	$0 copay per X-ray	
• Diagnostic radiology services (e.g. MRIs, CT scans, PET scans, etc.)	$0 copay per service	

*Service requires a referral and/or prior authorization.

Benefi s	You Pay	Important to Know
Hearing Services* • Medicare covered services **Hearing Services (routine)** • Routine exam (limit 1) • Hearing aid fitting and evaluation (limit 3) • Hearing aids This plan provides an **allowance of $600** per ear, per year for hearing aids.	$0 copay per service $0 copay per exam $0 copay per service $0 copay up to the maximum plan allowance amount	You must use a doctor in our network for routine services. Any unused allowance will expire December 31. After plan-paid benefits, you are responsible for the remaining cost and may use the flexible allowance as a form of payment. A deductible applies for a onetime replacement of lost, stolen, or damaged hearing aids.
Dental Services* • Medicare covered services **Dental Services (PPO)** **Preventive dental services include:** • Oral exam (limit 2) • Dental cleanings (limit 2) • Fluoride treatment (limit 1) • Bitewing X-ray (limit 2) **Comprehensive dental services include, but not limited to:** • Fillings and repairs • Root canals • Dental crowns • Implants • Bridges, dentures, extractions This plan provides a **bi-annual allowance of $1,100** for preventive and comprehensive services. The maximum annual benefit is $2,200.	$0 copay per service $0 copay up to the maximum plan allowance amount for preventive and/or comprehensive 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. 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. Any unused allowance will roll over to the next six-month period and expire December 31. Excludes orthodontia.

*Service requires a referral and/or prior authorization.

Benefi s	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)	$0 copay up to the maximum plan allowance amount.	
• Upgrades		
This plan provides an **annual allowance of $300** for eyewear.		
Mental Health Services*		The inpatient care lifetime limit applies to mental health services provided in a general hospital.
• Inpatient hospital - psychiatric	$150 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; $75 copay per day for days 21–100, per benefit period	No prior hospitalization is required.
Physical Therapy*		
• Occupational, physical, and speech and language	$0 copay per visit	
Ambulance		
• Ground transport	$100 copay per trip (each way)	
• Air transport	20% coinsurance per trip	
Transportation This plan provides **48 one-way** non-emergency rides.	$0 copay per trip	Rides to any 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

Benefi s	You Pay	Important to Know
Health and Wellness Flex Allowance This plan provides a **combined quarterly allowance of $315.** The annual maximum benefit is $1,260. **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 allowancefrom 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 **$2,000 every year**. **Eastern Wellness Services** This plan offers a maximum of **24** 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.

*Service requires a referral and/or prior authorization.

Benefi s	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 bloodwork 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 a medical or mental health Teladoc 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

Benefi s	You Pay	Important to Know
Worldwide Coverage This plan has an annual limit of $100,000 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.

Benefi s	You Pay	Important to Know
Special Supplemental Benefits for the Chronically Ill (SSBCI)* 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	**Healthy Food & Produce (Grocery)** After approval by the Plan, the flexible allowance will be made available to purchase approved healthy food and produce items. **Meals for Chronic Conditions** $0 copay for meal assistance up to 3 meals per day for 14 days; not to exceed 42 meals per year. **Telemonitoring Service** $0 copay for a device to monitor medical and other health data. **In-home Safety Assessment** $0 copay for up to 2 assessments per year. **In-home Support Services** $0 copay for services to assist with activities of daily living. Limited to 40 hours per year. **Social Needs Benefits** $0 copay for companionship services by non-clinical personal caregivers. Services are limited to 24 4-hour shifts (96 total hours). **Support for Caregivers** $0 copay for respite care. Limited to 40 hours per year.	The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify. 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.

Prescription Drug Coverage
Clever Care Longevity (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 your maximum out-of-pocket 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**	$40 copay	$120 copay	$80 copay	$40 copay
Tier 4: **Non-Preferred Brand**	$99 copay	$297 copay	$198 copay	$99 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 out-of-pocket drug cost reaches $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.			

[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.

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. 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.

Clever Care
HEALTH PLAN

VALUE

2026 Summary of Benefits

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

H7607_26_CM1446_M 09172025

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

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).

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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.

Medical & Hospital Benefits

Benefi s	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.

VALUE

Benefi s	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.

Benefi s	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

Benefi s	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.

*Service requires a referral and/or prior authorization.

VALUE

Benefi s	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:

Benefi s	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.

Benefi s	You Pay	Important to Know
Special Supplemental Benefits for the Chronically Ill (SSBCI)* 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	**Healthy Food & Produce (Grocery)** After approval by the Plan, the flexible allowance will be made available to purchase approved healthy food and produce items.	The benefit mentioned is part of a special supplemental program for the chronically ill. Not all members qualify. 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.

VALUE

*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.			

VALUE

[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.

VALUE

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. 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.

Clever Care HEALTH PLAN

2026 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.

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[1]
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

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.

TOTAL+

[1] 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.

You will see this if reduced cost-sharing applies. 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
Monthly Plan Premium (Part C & Part D)	$0	$0	You must continue to pay your Medicare Part B premium.
Deductible	$0	$615	This plan has deductibles for some hospital and medical services and Part D prescription drugs.
Maximum Out-of-Pocket Responsibility (excludes prescription drugs)	$0 annually	$9,250 annually	This is the most you will pay annually for covered Medicare services.

Medical & Hospital Benefits

Benefi s	With Full Medi-Cal You Pay	Without Medi-Cal You Pay	Important to Know
Inpatient Hospital Coverage*	$0 copay per benefit period	The following Medicare defi ed amounts are for 2026. • $1,736 deductible per benefit period • $0 copay per day for days 1–60, per benefit period and days 91 and more • $434 copay per day for days 61–90, per benefit period	
Outpatient Hospital Coverage* • Outpatient hospitalization • Observation services	$0 copay per stay $0 copay for observation services	20% coinsurance per stay 20% coinsurance for observation services	

*Service requires a referral and/or prior authorization.

Benefi s	With Full Medi-Cal You Pay	Without Medi-Cal You Pay	Important to Know
Ambulatory Surgical Center (ASC) Services*	$0 copay per visit	20% coinsurance per visit	
Doctor Visits			
• Primary care physician (PCP)	$0 copay per visit	$0 copay per visit	
• Specialist*	$0 copay per specialist visit	$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	$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	$0 per visit	$95 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	$25 copay per visit	
Diagnostic Services, Labs, and Imaging*			
• Lab services	$0 copay per lab service	20% coinsurance per lab service	
• Diagnostic tests, procedures	$0 copay per diagnostic service	$0 copay per diagnostic service	
• X-rays	$0 copay per X-ray	20% coinsurance per X-ray	
• Diagnostic radiology services (e.g. MRIs, CT scans, PET scans, etc.)	$0 copay per radiology service	20% coinsurance per radiology service	

TOTAL+

*Service requires a referral and/or prior authorization.

Benefi s	With Full Medi-Cal You Pay	Without Medi-Cal You Pay	Important to Know
Hearing Services*			You must use a doctor in our network for routine services.
• Medicare covered services	$0 copay per service	$0 copay per service	
Hearing Services (routine)			Any unused allowance will expire December 31.
• Routine hearing exam (limit 1)	$0 copay per exam or service	$0 copay per exam	After plan-paid benefits, you are responsible for the remaining cost and may use the flexible allowance as a form of payment.
• Hearing aid fitting and evaluation (limit 3)	$0 copay per exam or service	$0 copay per service	
• Hearing aids This plan provides an **allowance of $600** per ear, per year for hearing aids.	$0 copay up to the maximum plan allowance amount	$0 copay up to the maximum plan allowance amount	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	$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	$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.
Comprehensive dental services include, but not limited to:			After plan-paid benefits, you are responsible for the remaining cost and may use the flexible allowance as a form of payment.
• Fillings and repairs • Root canals • Dental crowns • Implants • Bridges, dentures, extractions This plan provides a **bi-annual allowance of $1,200** for preventive and comprehensive services. The maximum annual benefit is $2,400.			Any unused allowance will roll over to the next six-month period and expire December 31. Excludes orthodontia.

*Service requires a referral and/or prior authorization.

Benefi s	With Full Medi-Cal You Pay	Without Medi-Cal 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	$0 copay per exam	
• Medicare-covered glasses after cataract surgery	$0 copay per item	$0 copay per item	
Vision Services (routine)			
• Routine eye exam • Eyewear (frames, lenses, or contacts) • Upgrades This plan provides an **annual allowance of $350** for eyewear.	$0 copay per exam $0 copay up to the maximum plan allowance amount.	$0 copay per exam $0 copay up to the maximum plan allowance amount.	
Mental Health Services*		The following Medicare defi ed amounts are for 2026.	 The inpatient care lifetime limit does apply to mental health services provided in a general hospital.
• Inpatient hospital - psychiatric	$0 per stay per benefit period	• $1,736 deductible per benefit period • $0 copay per day for days 1–60, per benefit period and days 91 and more • $434 copay per day for days 61–90, per benefit period	
• Outpatient mental health care (group or individual therapy)	$0 copay per visit	20% coinsurance per visit	

TOTAL+

*Service requires a referral and/or prior authorization.

Benefi s	With Full Medi-Cal You Pay	Without Medi-Cal You Pay	Important to Know
Skilled Nursing Facility (SNF)*	$0 copay per stay	The following Medicare defi ed amounts are for 2026. • $0 copay, per day, for days 1–20 of each benefit period • $217 copay, per day, for days 21–100 of each benefit period	No prior hospitalization is required.
Physical Therapy* • Occupational, physical, and speech and language	$0 copay per visit	20% coinsurance per visit	
Ambulance • Ground transport • Air transport	$0 coinsurance per trip (each way) $0 coinsurance per trip	20% coinsurance per trip (each way) 20% coinsurance per trip	
Transportation This plan provides **48 one-way** 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.
Medicare Part B Drugs • Insulin • Chemotherapy and other Part B drugs	$0 copay $0 copay	0–20% coinsurance of the cost or the Medicare-allowed amount, not to exceed $35 0–20% coinsurance of the cost or the Medicare-allowed amount	Prices may change on a quarterly basis, but cost sharing will not exceed 20% coinsurance or $35 for insulin.

TOTAL+

*Service requires a referral and/or prior authorization.

Wellness benefits included in your plan

Benefi s	With Full Medi-Cal You Pay	Without Medi-Cal You Pay	Important to Know
Health and Wellness Flex Allowance This plan provides a **combined quarterly allowance of $600.** The annual maximum benefit is $2,400. **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 verifi d 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®.	$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 verifi d 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.

Benefi s	With Full Medi-Cal You Pay	Without Medi-Cal You Pay	Important to Know
Acupuncture Services (routine) This plan covers unlimited in-network, routine acupuncture services up to **$2,000 every year**.	$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. You must use a doctor in our network for routine services.
Eastern Wellness Services This plan offers a maximum of **24** wellness services per calendar year. Services include: • Cupping/Moxa • Tui Na, Gua Sha • Med-X, and Reflexology	$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.
Health and Wellness (routine) • Annual physical exam	$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.
Telehealth Visit Visits can take place using your phone, tablet, or computer. • Teladoc® visit (available 24-hours a day).	$0 copay for a medical or mental health Teladoc visit	$0 copay for a medical or mental health Teladoc visit	Teladoc providers can diagnose and treat non-emergent conditions and prescribe medications when necessary.
• Visit offered through your doctor's office.	$0 copay per visit	$0 copay per visit	

More benefits included in your plan

Benefi s	You Pay	Important to Know
Worldwide Coverage This plan has an annual limit of **$100,000** 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 per 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.

TOTAL+

*Service requires a referral and/or prior authorization.

Benefi s	You Pay	Important to Know
Special Supplemental Benefits for the Chronically Ill (SSBCI)* 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	**Healthy Food & Produce (Grocery)** After approval by the Plan, the flexible allowance will be made available to purchase approved healthy food and produce items. **Meals for Chronic Conditions** $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. **Telemonitoring Service** $0 copay for a device to monitor medical and other health data. **In-home Safety Assessment** $0 copay for up to 2 assessments per year. **In-home Support Services** $0 copay for services to assist with activities of daily living. Limited to 40 hours per year. **Social Needs Benefits** $0 copay for companionship services by non-clinical personal caregivers. Services are limited to 24 4-hour shifts (96 total hours). **Support for Caregivers** $0 copay for respite care. Limited to 40 hours per year.	The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify. Confi mation 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.

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. Members who qualify for Extra Help (the Medicare low-income subsidy program) may pay lower drug costs than those listed here.

Part D prescription drug benefit and what you pay.			
Stage 1: Annual Deductible	**$615** This annual deductible does not apply to Tiers 1, 2, or 6.		
Stage 2: Initial Coverage You pay the following until your maximum out-of-pocket reaches $2,100.	**Retail Standard Cost-sharing (In-network)**	**Mail-order Standard Cost-sharing**	**Retail Cost-sharing (Out-of-network)**[2]
	30–100 day supply	**100 day supply**	**30-day supply**
Tier 1: Preferred Generic	$0 copay	$0 copay	$0 copay
Tier 2: Generic	10% coinsurance	10% coinsurance	10% coinsurance
Tier 3: Preferred Brand	25% coinsurance	25% coinsurance	25% coinsurance
Tier 4: Non-Preferred Brand	25% coinsurance	25% coinsurance	25% coinsurance
Tier 5: Specialty Tier[2]	25% coinsurance	25% coinsurance	25% coinsurance
Tier 6: Select Care Drugs[3]	$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.		

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

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

TOTAL+

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Understanding the benefits

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- ☐ 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. 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 (01/26)

Clever Care HEALTH PLAN

2026 Summary of Benefits

Clever Care Breathe+ (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

BREATHE+

H7607_26_CM1311_M 01142026 Product

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 C-SNP plan, you must be:

1. entitled to Medicare Part A
2. enrolled in Medicare Part B
3. diagnosed with asthma, chronic bronchitis, emphysema, or COPD.[1]
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

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.

BREATHE+

[1] 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 Breathe+ (HMO C-SNP)**

A holistic plan for individuals diagnosed with asthma, chronic bronchitis, emphysema, or COPD.

You will see this if reduced cost-sharing applies.

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
Monthly Plan Premium (Part C & Part D)	$0	$0	You must continue to pay your Medicare Part B premium.
Deductible	$0	$615	This plan has deductibles for some hospital and medical services and Part D prescription drugs.
Maximum Out-of-Pocket Responsibility (excludes prescription drugs)	$0 annually	$9,250 annually	This is the most you will pay annually for covered Medicare services.

Medical & Hospital Benefits

Benefi s	With Full Medi-Cal You Pay	Without Medi-Cal You Pay	Important to Know
Inpatient Hospital Coverage*	$0 copay per benefit period	The following Medicare defi ed amounts are for 2026. • $1,736 deductible per benefit period • $0 copay per day for days 1–60, per benefit period and days 91 and more • $434 copay per day for days 61–90, per benefit period	
Outpatient Hospital Coverage* • Outpatient hospitalization • Observation services	$0 copay per stay $0 copay for observation services	20% coinsurance per stay 20% coinsurance for observation services	

*Service requires a referral and/or prior authorization.

Benefi s	With Full Medi-Cal You Pay	Without Medi-Cal You Pay	Important to Know
Ambulatory Surgical Center (ASC) Services*	$0 copay per visit	20% coinsurance per visit	
Doctor Visits			
• Primary care physician (PCP)	$0 copay per visit	$0 copay per visit	
• Specialist*	$0 copay per specialist visit	$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	$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	$0 per visit	$95 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	$25 copay per visit	
Diagnostic Services, Labs, and Imaging*			
• Lab services	$0 copay per lab service	20% coinsurance per lab service	
• Diagnostic tests, procedures	$0 copay per diagnostic service	$0 copay per diagnostic service	
• X-rays	$0 copay per X-ray	20% coinsurance per X-ray	
• Diagnostic radiology services (e.g. MRIs, CT scans, PET scans, etc.)	$0 copay per radiology service	20% coinsurance per radiology service	

BREATHE+

*Service requires a referral and/or prior authorization.

Benefi s	With Full Medi-Cal You Pay	Without Medi-Cal You Pay	Important to Know
Hearing Services* • Medicare covered services **Hearing Services (routine)** • Routine hearing exam (limit 1) • Hearing aid fitting and evaluation (limit 3) • Hearing aids This plan provides an **allowance of $600** per ear, per year for hearing aids.	$0 copay per service $0 copay per exam or service $0 copay per exam or service $0 copay up to the maximum plan allowance amount	$0 copay per service $0 copay per exam $0 copay per service $0 copay up to the maximum plan allowance amount	You must use a doctor in our network for routine services. Any unused allowance will expire December 31. After plan-paid benefits, you are responsible for the remaining cost and may use the flexible allowance as a form of payment. A deductible applies for a one-time replacement of lost, stolen, or damaged hearing aids.
Dental Services* • Medicare covered services **Dental Services (PPO)** **Preventive dental services include:** • Oral exam (limit 2) • Dental cleanings (limit 2) • Fluoride treatment (limit 1) • Bitewing X-ray (limit 2) **Comprehensive dental services include, but not limited to:** • Fillings and repairs • Root canals • Dental crowns • Implants • Bridges, dentures, extractions This plan provides a **bi-annual allowance of $1,200** for preventive and comprehensive services. The maximum annual benefit is $2,400.	$0 copay per service $0 copay up to the maximum plan allowance amount for preventive and/or comprehensive services	$0 copay per service $0 copay up to the maximum plan allowance amount for preventive and/or comprehensive 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. 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. Any unused allowance will roll over to the next six-month period and expire December 31. Excludes orthodontia.

*Service requires a referral and/or prior authorization.

Benefi s	With Full Medi-Cal You Pay	Without Medi-Cal 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	$0 copay per exam	
• Medicare-covered glasses after cataract surgery	$0 copay per item	$0 copay per item	
Vision Services (routine)			
• Routine eye exam • Eyewear (frames, lenses, or contacts) • Upgrades This plan provides an **annual allowance of $350** for eyewear.	$0 copay per exam $0 copay up to the maximum plan allowance amount.	$0 copay per exam $0 copay up to the maximum plan allowance amount.	
Mental Health Services*		The following Medicare defi ed amounts are for 2026.	 The inpatient care lifetime limit does apply to mental health services provided in a general hospital.
• Inpatient hospital - psychiatric	$0 per stay per benefit period	• $1,736 deductible per benefit period • $0 copay per day for days 1–60, per benefit period and days 91 and more • $434 copay per day for days 61–90, per benefit period	
• Outpatient mental health care (group or individual therapy)	$0 copay per visit	20% coinsurance per visit	

*Service requires a referral and/or prior authorization.

Benefi s	With Full Medi-Cal You Pay	Without Medi-Cal You Pay	Important to Know
Skilled Nursing Facility (SNF)*	$0 copay per stay	The following Medicare defi ed amounts are for 2026. • $0 copay, per day, for days 1–20 of each benefit period • $217 copay, per day, for days 21–100 of each benefit period	No prior hospitalization is required.
Physical Therapy* • Occupational, physical, and speech and language	$0 copay per visit	20% coinsurance per visit	
Ambulance • Ground transport • Air transport	$0 coinsurance per trip (each way) $0 coinsurance per trip	20% coinsurance per trip (each way) 20% coinsurance per trip	
Transportation This plan provides **48 one-way** 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.
Medicare Part B Drugs • Insulin • Chemotherapy and other Part B drugs	$0 copay $0 copay	0–20% coinsurance of the cost or the Medicare-allowed amount, not to exceed $35 0–20% coinsurance of the cost or the Medicare-allowed amount	Prices may change on a quarterly basis, but cost sharing will not exceed 20% coinsurance or $35 for insulin.

Wellness benefits included in your plan

Benefi s	With Full Medi-Cal You Pay	Without Medi-Cal You Pay	Important to Know
Health Education Wellness Kit This plan will provide all enrollees a wellness kit tailored for lung health.	$0 copay for the kit	$0 copay for the kit	

*Service requires a referral and/or prior authorization.

Benefi s	With Full Medi-Cal You Pay	Without Medi-Cal You Pay	Important to Know
Health and Wellness Flex Allowance This plan provides a **combined quarterly allowance of $600.** The annual maximum benefit is $2,400. **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 verifi d 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®.	$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 verifi d by your PCP. This benefit is limited to healthy food and produce and excludes tobacco and alcohol and other restricted items.

BREATHE+

*Service requires a referral and/or prior authorization.

Benefi s	With Full Medi-Cal You Pay	Without Medi-Cal You Pay	Important to Know
Acupuncture Services (routine) This plan covers unlimited in-network, routine acupuncture services up to **$2,000 every year**.	$0 copay, per visit, up to the plan maximum amount	$0 copay, per visit, up to the plan maximum amount	You must use a doctor in our network for routine services. After plan-paid benefits, you are responsible for the remaining costs.
Eastern Wellness Services This plan offers a maximum of **24** wellness services per calendar year. Services include: • Cupping/Moxa • Tui Na, Gua Sha • Med-X, and Reflexology	$0 copay, per visit, up to the maximum allowed visits	$0 copay, per visit, up to the maximum allowed visits	Any allowance amount not used will expire December 31.
Health and Wellness (routine) • Annual physical exam	$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.
Telehealth Visit Visits can take place using your phone, tablet, or computer. • Teladoc® visit (available 24-hours a day).	$0 copay for a medical or mental health Teladoc visit	$0 copay for a medical or mental health Teladoc visit	Teladoc providers can diagnose and treat non-emergent conditions and prescribe medications when necessary.
• Visit offered through your doctor's office.	$0 copay per visit	$0 copay per visit	

More benefits included in your plan

Benefi s	You Pay	Important to Know
Worldwide Coverage This plan has an annual limit of **$100,000** 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 per 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.

BREATHE+

*Service requires a referral and/or prior authorization.

Benefi s	You Pay	Important to Know
Special Supplemental Benefits for the Chronically Ill (SSBCI)* 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	**Healthy Food & Produce (Grocery)** After approval by the Plan, the flexible allowance will be made available to purchase approved healthy food and produce items. **Meals for Chronic Conditions** $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. **Telemonitoring Service** $0 copay for a device to monitor medical and other health data. **In-home Safety Assessment** $0 copay for up to 2 assessments per year. **In-home Support Services** $0 copay for services to assist with activities of daily living. Limited to 40 hours per year. **Social Needs Benefits** $0 copay for companionship services by non-clinical personal caregivers. Services are limited to 24 4-hour shifts (96 total hours). **Support for Caregivers** $0 copay for respite care. Limited to 40 hours per year.	The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify. Confi mation 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.

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Prescription Drug Coverage
Clever Care Breathe+ (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. Members who qualify for Extra Help (the Medicare low-income subsidy program) may pay lower drug costs than those listed here.

Part D prescription drug benefit and what you pay.			
Stage 1: Annual Deductible	**$615** This annual deductible does not apply to Tier 6.		
Stage 2: Initial Coverage You pay the following until your maximum out-of-pocket reaches $2,100.	**Retail Standard Cost-sharing (In-network)**	**Mail-order Standard Cost-sharing**	**Retail Cost-sharing (Out-of-network)**[2]
	30–100 day supply	**100 day supply**	**30-day supply**
Tier 1: Preferred Generic	25% coinsurance	25% coinsurance	25% coinsurance
Tier 2: Generic	25% coinsurance	25% coinsurance	25% coinsurance
Tier 3: Preferred Brand	25% coinsurance	25% coinsurance	25% coinsurance
Tier 4: Non-Preferred Brand	25% coinsurance	25% coinsurance	25% coinsurance
Tier 5: Specialty Tier[2]	25% coinsurance	25% coinsurance	25% coinsurance
Tier 6: Select Care Drugs[3]	$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.		

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

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

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- ☐ 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

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M11129-SB-BRP-EN (01/26)

Clever Care HEALTH PLAN

Prescription Drugs

Clever Care Health Plan continually strives to provide you with easy access to your medications. One example is that in 2026, CGMs (continuous glucose monitors) will no longer require a prior authorization. That means less paperwork for your doctor and no delay for you. You just need a prescription for one of our formulary CGM systems and the pharmacy can fill it for you.

Will be covered without a prior authorization (need a prescription like other drugs):	**Manual glucometer set will continue to be covered:**
• Freestyle Libre 2 • Freestyle Libre 2 plus • Freestyle Libre 3 • Freestyle Libre 3 plus • Dexcom 6 • Dexcom 7	• Freestyle Lite system
Quantity will be per manufacture use recommendation (some use one sensor every 14 days, some every 10 days, etc).	Does not need a prior authorization; just a prescription.

The chart is just an example of some of the most commonly used drugs and their tier—you will notice that most of the drugs are on tier 1 or 6, meaning as low as $0 out-of-pocket for most members. More drugs may be added throughout the year.

Top 50 Drugs

This is not a complete list of what's covered.
Scan here for our most up-to-date list.

	Drug Name	Tier
1	ATORVASTATIN CALCIUM	6
2	AMLODIPINE BESYLATE	1
3	LOSARTAN POTASSIUM	6
4	METFORMIN HCL	6
5	VASCEPA	3
6	ROSUVASTATIN CALCIUM	1
7	TAMSULOSIN HCL	1
8	OMEPRAZOLE	1
9	JARDIANCE	3
10	METOPROLOL SUCCINATE	1
11	RESTASIS	3
12	GABAPENTIN	1 or 2
13	FARXIGA	3
14	ALENDRONATE SODIUM	1
15	LEVOTHYROXINE SODIUM	2
16	LIDOCAINE PATCH 5%	2
17	LATANOPROST	1
18	TRIAMCINOLONE ACETONIDE	1
19	AZELASTINE HCL	2
20	CELECOXIB	2
21	AMOXICILLIN	1
22	PANTOPRAZOLE SODIUM	1
23	MONTELUKAST SODIUM	1
24	AZITHROMYCIN	2
25	FLUTICASONE PROPIONATE	2

	Drug Name	Tier
26	FINASTERIDE	1
27	IBUPROFEN	1
28	JANUVIA	3
29	CLOPIDOGREL	1
30	FAMOTIDINE	1
31	LEVOCETIRIZINE DIHYDROCHLORIDE	2
32	ALBUTEROL SULFATE HFA	2
33	MELOXICAM	1
34	OLMESARTAN MEDOXOMIL	1
35	ZOLPIDEM TARTRATE	2
36	LOSARTAN-HYDROCHLOROTHIAZIDE	6
37	LISINOPRIL	6
38	DONEPEZIL HCL	1
39	SIMVASTATIN	6
40	EZETIMIBE	2
41	ALLOPURINOL	1
42	PIOGLITAZONE HCL	6
43	TRAZODONE HCL	1
44	METFORMIN HCL ER	6
45	CREON	3
46	ELIQUIS	4
47	LANTUS (INSULIN)	3
48	FENOFIBRATE	2
49	TRADJENTA	3
50	GLIPIZIDE	6

IMPORTANT INFORMATION:

2026 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Clever Care Health Plan - H7607

For 2026, Clever Care Health Plan - H7607 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★½☆
Health Services Rating:	★★★½☆
Drug Services Rating:	★★★½☆

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at Medicare.gov/plan-compare.

Questions about this plan?

Contact Clever Care Health Plan 7 days a week from 8:00 a.m. to 8:00 p.m. Pacific time at 833-388-8168 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Pacific time. Current members please call 833-388-8168 (toll-free) or 711 (TTY).

Clever Care Health Plan, Inc. is an HMO and HMO C-SNP with a Medicare contract. Enrollment depends on contract renewal.

Clever Care™
HEALTH PLAN

Monthly Plan Premium for People who get Extra Help from Medicare to Help Pay for their Prescription Drug Costs

If you get Extra Help from Medicare to help pay for your Medicare prescription drug plan costs, your monthly plan premium will be lower than what it would be if you did not get Extra Help from Medicare.

If you get Extra Help, your monthly plan premium will be $0 for any of the plan(s) below. (This does not include any Medicare Part B premium you may have to pay.)

- Clever Care Longevity (HMO)
- Clever Care Value (HMO)
- Clever Care Total+ (HMO C-SNP)
- Clever Care Breathe+ (HMO C-SNP)

Clever Care Health Plan's premium includes coverage for both medical services and prescription drug coverage.

If you aren't getting Extra Help, you can see if you qualify by calling:

- 1-800-MEDICARE or TTY users call 1-877-486-2048 (24 hours a day/7 days a week),
- Your State Medicaid Office, or
- The Social Security Administration at 1-800-772-1213, TTY users should call 1-800-325-0778 between 7 a.m. and 7 p.m., Monday through Friday.

If you have any questions, please call Member Services at (833) 388-8168 (TTY/TDD users should call 711) from 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. Hours listed are for the Pacific time zone.

Clever Care Health Plan, Inc. is an HMO and HMO C-SNP with a Medicare contract. Enrollment depends on contract renewal.

H7607_26_CM1413_C 08132025

M10903-LISS-EN (08/25)

Clever Care HEALTH PLAN

Non-Discrimination and Accessibility Requirements

Discrimination is Against the Law

Clever Care Health Plan Inc. (herein referred to as Clever Care) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Clever Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Clever Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call (833) 388-8168 (TTY: 711).

If you believe that Clever Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:

Clever Care Health Plan
Attn: Civil Rights Coordinator
7711 Center Ave
Suite 100
Huntington Beach CA 92647

E-mail: civilrightscoordinator@ccmapd.com
Fax: (657) 276-4721

You can file a grievance by mail, fax, or email. If you need help filing a grievance, our Clever Care Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Clever Care
HEALTH PLAN

Notice Of Availability

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-833-388-8168 (TTY: 711) or speak to your provider.

Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-833-388-8168 (TTY: 711) o hable con su proveedor.

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-833-388-8168 (TTY: 711) o makipag-usap sa iyong provider.

中文： 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-833-808-8153 (国语) / 1-833-808-8161 (粵语)（TTY: 711）或咨询您的服务提供商。

台語: 注意：如果您說[台語]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-833-808-8153 (國語) / 1-833-808-8161 (粵語)（TTY: 711）或與您的提供者討論。

Việt: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-833-808-8163 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

한국어: 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-833-808-8164 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

ՀԱՅԵՐԵՆ: ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, Դուք կարող եք օգտվել լեզվական աջակցության անվճար ծառայություններից: Մատչելի ձևաչափերով տեղեկատվություն տրամադրելու համապատասխան օժանդակ միջոցներն ու ծառայությունները նույնպես տրամադրվում են անվճար: Զանգահարեք 1-833-388-8168 հեռախոսահամարով (TTY՝ 711) կամ խոսեք Ձեր մատակարարի հետ:

РУССКИЙ: ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-833-388-8168 (TTY: 711) или обратитесь к своему поставщику услуг.

فارسي

توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-833-388-8168 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

العربية
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-833-388-8168 (TTY: 711) أو تحدث إلى مقدم الخدمة".

ភាសាខ្មែរ: សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ *ភាសាខ្មែរ*សេវាកម្មជំនួយភាសា តតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបាន ដោយតតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ 1-833-388-8168 (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។”

日本語: 注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-833-388-8168（TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。

ਪੰਜਾਬੀ: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 1-833-388-8168 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।

ไทย: หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-833-388-8168 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ

Lus Hmoob: LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-833-388-8168 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

Clever Care HEALTH PLAN

Enrollment

Enroll in Clever Care Health Plan



Your broker will complete the Scope of Appointment form



Complete the enrollment application
(you will need to have your Medicare ID Card)



Sign and return the application to Clever Care

Enroll in 4 easy steps

Step 1	**Verify you are eligible to enroll.**
Step 2	**Select a Clever Care Medicare Advantage plan.** To enroll in Clever Care **Total+** (HMO C-SNP) you must attest on the enrollment form to having diabetes, chronic heart failure (CHF), or a cardiovascular disorder. To enroll in Clever Care **Breathe+** (HMO C-SNP) you must attest on the enrollment form to having asthma, chronic bronchitis, emphysema, or COPD.
Step 3	**Choose your primary care physician (PCP).** Find participating providers at clevercarehealthplan.com/provider. Write down the PCPs name and ID number. You will need this to complete the enrollment form.
Step 4	**Complete and return the enrollment form.**

You've enrolled! Now what?

Once your enrollment application is received by Clever Care Health Plan, we will immediately start processing your enrollment. You will receive the following within 30 days of enrolling.



Confirmation of enrollment letter
Within 10 days after Medicare approves your enrollment you will receive a letter from Clever Care confirming your enrollment.



Clever Care member ID card
Your new ID card will be mailed to you within 10 days of your confirmed enrollment. You will also receive information about your Evidence of Coverage (EOC) and other plan documents.



Clever Care Welcome
You will receive a Member Guide in the mail with information about how to get the most from your health plan and a welcome call to answer all your questions.

If you qualify for "Extra Help" from Medicare for your drug coverage, then you will receive a "LIS" (Low Income Subsidy) letter within 10 days of your verified enrollment.

Clever Care
HEALTH PLAN

Scope Of Sales Appointment Confirmation

The Centers for Medicare and Medicaid Services (CMS) requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial beside the type of product you want the agent to discuss.

Clever Care Medicare Advantage and Prescription Drug Plans (Part C)

_____ **Medicare Health Maintenance Organization (HMO):** A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

_____ **Medicare Chronic Special Needs Plan (C-SNP):** A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. An example of the specific groups served include people who have certain chronic medical conditions.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initiated above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Signature:	**Date:** M M / D D / Y Y Y Y

If you are the authorized representative, sign above and print below.

Representative's Name:	**Your Relationship to the Beneficiary:**

AGENT SECTION: Return this form along with the completed enrollment application	
Agent Name:	**Agent Phone:** ( ) _____ – _____
Beneficiary Name:	**Beneficiary Phone (optional):** ( ) _____ – _____
Beneficiary Address:	
Indicate method of contact: ☐ Sales event ☐ Walk-in ☐ Inbound call ☐ Permission to call card	
If the form was signed by the beneficiary at the time of appointment, explain why it was not documented prior to the meeting:	
Agent's Signature:	**Date Appointment Completed:** M M / D D / Y Y Y Y

Scope of Appointment documentation is subject to CMS record retention requirements.

Clever Care HEALTH PLAN

2026 Individual Enrollment Request Form

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of fi st getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fi l them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

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

Email: enrollment@ccmapd.com

Fax: (657) 276-4757

Once they process your request to join, they will contact you.

How do I get help with this form?

Call Clever Care at (833) 388-8168. TTY users can call 711. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En Español: Llame a Clever Care al (833) 388-8168/711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en Español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Section 1	All fields on this page are required (unless marked optional)

Select the plan you want to join:

☐	Clever Care **Longevity** (HMO)	H7607-014-000	$0 per month
☐	Clever Care **Value** (HMO)	H7607-015-000	$0 per month
☐	Clever Care **Total+** (HMO C-SNP)	H7607-016-000	$0 per month
☐	Clever Care **Breathe+** (HMO C-SNP)	H7607-017-000	$0 per month

LAST name:

FIRST name:	**M.I.** (optional):

Birth date: M M / D D / Y Y Y Y	**Sex:** ☐ Male ☐ Female

Phone Number:

( ) –

Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:	**State:**	**ZIP Code:**

Mailing Address, if different from your permanent address (PO Box allowed):

City:	**State:**	**ZIP Code:**

Your Medicare information:

Medicare Number:

_____ – _____ – _____

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Clever Care? ☐ Yes ☐ No

Name of other coverage:

Member number for this coverage:	Group number for this coverage:

OPTIONAL:

Are you enrolled in your state Medi-Cal (Medicaid) program? ☐ Yes ☐ No

If "yes," please provide your Medi-Cal (Medicaid) number:

Based on Model of Care Review, Clever Care Health Plan, Inc., has been approved by the National Committee for Quality Assurance (NCQA) to operate a Chronic Special Needs Plan (C-SNP) through 2026.

Section 1	**All fields on this page are required (unless marked optional)** *continued*

Complete only if you are enrolling in Clever Care Total+ (HMO C-SNP) plan

Have you been diagnosed with **diabetes** (high blood sugar) or are you taking insulin or other medications to control you blood sugar?	☐ Yes	☐ No
Have you been diagnosed with **cardiac arrhythmia** or atrial fi rillation (Afi) or have you had problems with rapid, irregular heartbeat?	☐ Yes	☐ No
Have you been diagnosed with **coronary artery disease (CAD)**, had a heart attack, or experienced poor circulation due to hardening of the arteries or veins?	☐ Yes	☐ No
Have you been diagnosed with **chronic venous thromboembolic disorder** or had blood clots in the veins more than once?	☐ Yes	☐ No
Have you been diagnosed with **Peripheral Vascular Disease (PVD)** or experienced symptoms like leg pain when walking, foot numbness at night, non-healing leg sores, or coldness in one leg?	☐ Yes	☐ No
Have you been diagnosed with **Chronic Heart Failure (CHF)**, or do you often experience shortness of breath, fatigue, or swelling in your legs or ankles during daily activities or while lying down?	☐ Yes	☐ No

Complete only if you are enrolling in Clever Care Breathe+ (HMO C-SNP) plan

Have you been diagnosed with **asthma** or do you frequently experience wheezing, shortness of breath, chest tightness, or coughing, especially at night or after physical activity?	☐ Yes	☐ No
Have you been diagnosed with **chronic bronchitis** or do you have a persistent cough with mucus that lasts for at least three months in a year for two consecutive years?	☐ Yes	☐ No
Have you been diagnosed with **emphysema** or do you experience frequent shortness of breath, especially during physical activity, along with a chronic cough or wheezing?	☐ Yes	☐ No
Have you been diagnosed with **chronic obstructive pulmonary disease (COPD)** or often have shortness of breath, a chronic cough with mucus, or frequent wheezing?	☐ Yes	☐ No

Are you taking medications to treat your conditions? ☐ Yes ☐ No

If yes, list the medications:

Physician who can verify your condition(s)

Name:

Phone: ( ) –	**Fax:** ( ) –

Office Address:

City:	**State:**	**ZIP Code:**

Section 1	**All fields on this page are required (unless marked optional)** *continued*

Authorization for Disclosure of Health Information
My signature authorizes the provider listed above and/or my PCP to disclose my health information and/or provide medical records to Clever Care Health Plan.

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Clever Care Health Plan.
- By joining this Medicare Advantage Plan, I acknowledge that Clever Care will share my information with Medicare, who may use it to track my enrollment, make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Clever Care Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Clever Care Health Plan. Benefits and services provided by Clever Care Health Plan and contained in my Clever Care Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Clever Care will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifi s that:
    1. this person is authorized under State law to complete this enrollment, and
    2. documentation of this authority is available upon request by Medicare.

Signature:	**Today's date:** M M / D D / Y Y Y Y

If you're the authorized representative, sign above and fill out these fields:

Name:	Address:
Phone number: ( ) –	Relationship to enrollee:

Section 2	All fields on this page are optional

Answering these questions is your choice. You cannot be denied coverage because you don't fill them out.

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native[1]
- ☐ Asian Indian[2]
- ☐ Black or African American[3]
- ☐ Chinese[4]
- ☐ Cambodian[5]
- ☐ Filipino[6]
- ☐ Guamanian or Chamorro[7]
- ☐ Japanese[8]
- ☐ Korean[9]
- ☐ Native Hawaiian[10]
- ☐ Other Asian[11]
- ☐ Other Pacific Islander[12]
- ☐ Samoan[13]
- ☐ Vietnamese[14]
- ☐ White[15]
- ☐ **I choose not to answer.**[16]

What is your preferred spoken language?

☐ English ☐ Mandarin ☐ Cantonese ☐ Khmer ☐ Korean ☐ Vietnamese ☐ Spanish
☐ Other: _____

What is your preferred written language, other than English?

☐ Chinese (traditional) ☐ Korean ☐ Vietnamese ☐ Spanish

Select one if you want us to send you information in an accessible format:

☐ Braille ☐ Large print ☐ Data CD

Please contact Clever Care at (833) 388-8168 if you need information in an accessible format other than what's listed above. Our office hours are 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. TTY users can call 711.

Do you work? ☐ Yes ☐ No **Does your spouse work?** ☐ Yes ☐ No

Texting and Email Opt-in:

Mobile phone number: ( ) _____ – _____

By providing my number, I agree to receive automated and/or other text messages by Clever Care Health Plan for healthcare, benefits, or any other purpose. Such consent is not a condition of receipt of any service and I can opt out at any time by calling Clever Care. Message and data rates may apply.

Email Address: _____

By providing my email address, I agree to receive Clever Care communications and materials electronically rather than by U.S. Mail. I understand this would include documents such as the Part C and Part D Explanation of Benefits (EOB), Annual Notice of Change (ANOC) and other materials. I can change back to U.S. mail at any time by calling Clever Care.

List your Primary Care Physician (PCP)

Name of PCP:

Medical Group or IPA:

PCP Enrollment ID #:

Are you a current patient of this PCP? ☐ Yes ☐ No ☐ I do not have a PCP, please assign one to me.

Section 3 | Paying your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DO NOT pay Clever Care the Part D-IRMAA.

Please select a premium payment option. If you don't make a selection you will receive a bill.

- ☐ Get a bill.
- ☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from: ☐ i) Social Security ☐ ii) RRB

Thank you for choosing Clever Care Health Plan! (optional)

Please take a moment to share how you found Clever Care. Select one or more of the following examples:

- ☐ Television[1]
- ☐ Radio[2]
- ☐ Newspaper[3]
- ☐ Social media or computer (Google, Facebook, YouTube, Game app)[4]
- ☐ Mail[5]
- ☐ Family, friend, doctor, or acupuncturist[6]
- ☐ Your insurance broker[7]
- ☐ Event[8]
- ☐ Other:[9] _____

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fi l out this form.

Name:	Relationship to enrollee:
Signature:	National Producer Number (Agents/Brokers only):
FMO (if applicable):	Telephonic Application?: ☐ Yes ☐ No
Effective date of coverage: M M / D D / Y Y Y Y	Date application was received: M M / D D / Y Y Y Y

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Attestation of eligibility for an enrollment period.

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period. **Please read the following statements carefully and check the box that applies to you.** By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.[1]
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).[2]
- ☐ I am new to Medicare and want to change my advantage plan within 3 months of having Part A/B.[3]
- ☐ I had Medicare before, but I am now turning 65.[4]
- ☐ I already have Hospital (Part A) and recently signed up for Medical (Part B). I want to join a Medicare Advantage plan.[5]
- ☐ I recently moved outside of the service area for my current plan or I recently moved and have new options available to me. I moved on _____ / _____ / _____.[6]
- ☐ I recently was released from incarceration. I was released on _____ / _____ / _____.[7]
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on _____ / _____ / _____.[8]
- ☐ I recently obtained lawful presence status in the United States. I got this status on _____ / _____ / _____.[9]
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on _____ / _____ / _____.[10]
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on _____ / _____ / _____.[11]
- ☐ I am moving into, live in or recently moved out of a Long-term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on _____ / _____ / _____.[12]
- ☐ I recently left a PACE® program on _____ / _____ / _____.[13]
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on _____ / _____ / _____.[14]
- ☐ I am leaving/losing employer or union coverage on _____ / _____ / _____.[15]
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.[16]
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on _____ / _____ / _____.[17]
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on _____ / _____ / _____.[18]
- ☐ I was affected by an emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.[19]
- ☐ I want to join a Special Needs Plan that tailors its benefits to my chronic conditions.[20]

If none of these statements applies to you or you're not sure, please contact Clever Care at **(833) 388-8168 (TTY: 711)** to see if you are eligible to enroll.