



2024 Summary of Benefits

Clever Care Active (HMO)

A Medicare Advantage and Prescription Drug Plan

Serving California

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

Plan Year: January 1, 2024 - December 31, 2024

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

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

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

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

clevercarehealthplan.com/provider



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

clevercarehealthplan.com/formulary



If you need help understanding this information, call us at **1-833-388-8168 (TTY:711)** 8 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. 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](https://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.



2024 Summary of Benefits

Clever Care Active (HMO) | A wellness-focused plan with a Part B buydown.

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 \$50 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.)	\$2,500 annually	This is the most you would pay, for the year, for covered Medicare services.

Medical & Hospital Benefits

Benefits	You Pay	Important to Know
Inpatient Hospital Coverage*	\$100 copay per day, for days 1-5; \$0 copay per day, for days 6-90, per benefit period	
Outpatient Hospital Coverage* <ul style="list-style-type: none"> Outpatient hospitalization Observation services 	\$0 copay per stay \$0 copay for observation services	
Ambulatory Surgical Center (ASC) Services*	\$0 copay per stay	
Doctor Visits <ul style="list-style-type: none"> Primary care physician (PCP) Specialist* 	\$0 copay per visit \$5 copay per specialist visit	
Preventive Care <ul style="list-style-type: none"> Welcome to Medicare visit or Annual wellness visit and all other preventive care services covered by Medicare 	\$0 copay per Medicare-covered 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 <ul style="list-style-type: none"> Emergency room 	\$75 copay per visit	The copay is waived if you are admitted to the hospital within 72 hours for the same condition.
Urgently Needed Services <ul style="list-style-type: none"> Urgent Care Center 	\$0 copay per visit	

*Service requires a referral and/or prior authorization.

Benefits	You Pay	Important to Know
<p>Diagnostic Services, Labs, and Imaging*</p> <ul style="list-style-type: none"> • Lab services • Diagnostic tests, procedures • X-rays • Diagnostic radiology services (e.g. MRIs, CT scans, PET scans, etc.) 	<p>\$0 copay per service \$0 copay per service \$0 copay per service \$50 copay per diagnostic radiology or \$0 copay for basic radiology service</p>	
<p>Hearing Services*</p> <ul style="list-style-type: none"> • Medicare covered services <p>Hearing Services (routine)</p> <ul style="list-style-type: none"> • Routine hearing exam (limit 1) • Hearing aid fitting and evaluation (limit 3) • Hearing aids <p>This plan provides an allowance of \$600 per ear, per year for hearing aids.</p>	<p>\$0 copay per Medicare covered service</p> <p>\$0 copay per exam \$0 copay per service</p> <p>\$0 copay up to the maximum plan allowance amount</p>	<p>You must use a doctor in the Nations Hearing network for routine services.</p> <p>After plan-paid benefits, you are responsible for the remaining cost.</p> <p>Any allowance amount not used will expire December 31.</p> <p>A deductible applies for a one-time replacement of lost, stolen, or damaged hearing aids.</p>
<p>Dental Services*</p> <ul style="list-style-type: none"> • Medicare covered services <p>Dental Services (PPO)*</p> <p>Preventive dental services include:</p> <ul style="list-style-type: none"> • Oral exam (limit 2) • Dental cleanings (limit 2) • Fluoride treatment (limit 1) • Bitewing X-ray (Limit 2) • Dental X-ray (limit 1) <p>Comprehensive dental services include, but not limited to:</p> <ul style="list-style-type: none"> • Fillings and repairs • Root canals • Dental crowns (Caps) • Implants • Bridges, dentures, extractions <p>This plan provides a quarterly allowance of \$300 for preventive and comprehensive services. The maximum annual benefit is \$1,200.</p>	<p>\$0 copay per Medicare covered service</p> <p>\$0 copay up to the maximum plan allowance amount</p>	<p>Prior authorization is required for implants, Cone Beam CT capture, restorative crowns, and fixed prosthodontics.</p> <p>There is no requirement to stay in-network. However, using a Liberty Dental provider may lower your out-of-pocket cost.</p> <p>For services obtained out-of-network, the plan pays up to the allowed amount for covered services up to the quarterly plan maximum. You may be responsible for additional cost up to the providers billed amount.</p> <p>After plan-paid benefits, you are responsible for the remaining cost.</p> <p>Any allowance amount not used by March 31, June 30, or September 30, will roll over to the next quarter, and expire December 31.</p> <p>Excludes orthodontia.</p>

*Service requires a referral and/or prior authorization.

Benefits	You Pay	Important to Know
<p>Vision Services*</p> <ul style="list-style-type: none"> • Medicare-covered vision exam to diagnose/treat diseases and conditions of the eye • Medicare-covered glasses after cataract surgery <p>Vision Services (routine)</p> <ul style="list-style-type: none"> • Routine eye exam • Eyewear (frames, lenses, or contacts) • Upgrades <p>This plan provides an annual allowance of \$200 for eyewear.</p>	<p>\$0 copay per exam</p> <p>\$0 copay per item</p> <p>\$0 copay per exam</p> <p>\$0 copay up to the maximum plan allowance amount.</p>	<p>You must use a doctor in the VSP Vision Care network for routine services.</p> <p>After plan-paid benefits for routine services, you are responsible for the remaining costs. If you go to an out-of-network provider, you pay the full cost.</p> <p>Any allowance amount not used will expire December 31.</p>
<p>Mental Health Services*</p> <ul style="list-style-type: none"> • Inpatient mental health care • Outpatient mental health care (group or individual therapy) 	<p>\$175 copay per day for days 1–7; \$0 copay per day for days 8–90, per benefit period</p> <p>\$40 copay per visit</p>	<p>The inpatient care lifetime limit does apply to mental health services provided in a general hospital.</p>
<p>Skilled Nursing Facility (SNF)*</p>	<p>\$0 copay per day for days 1–20; \$180 copay per day for days 21–100, per benefit period</p>	<p>No prior hospitalization is required.</p>
<p>Physical Therapy*</p> <ul style="list-style-type: none"> • Occupational • Physical and speech and language 	<p>\$0 copay per visit</p>	
<p>Ambulance</p> <ul style="list-style-type: none"> • Ground transport • Air transport 	<p>\$75 copay per trip (each way)</p> <p>20% coinsurance</p>	
<p>Transportation</p> <p>This plan provides 16 one-way non-emergency rides.</p>	<p>\$0 copay per trip</p>	<p>Rides to an approved health-related location are limited to a 25-mile radius.</p>
<p>Medicare Part B Drugs*</p>	<p>0–20% coinsurance</p>	<p>0–20% coinsurance of the cost or the Medicare-allowed coinsurance amount, whichever is lower for chemotherapy and other Part B drugs. Prices may change on a quarterly basis, but cost sharing will not exceed 20% coinsurance.</p>

*Service requires a referral and/or prior authorization.

Wellness benefits included in your plan

Benefits	You Pay	Important to Know
<p>Fitness Flex Allowance</p> <p>This plan provides a quarterly allowance of \$250. The maximum annual benefit is \$1,000.</p> <p>Fitness activities include, but are not limited to:</p> <ul style="list-style-type: none"> • Golf, table tennis • Tai Chi, yoga • Gym membership 	<p>\$0 copay up to the maximum plan allowance amount, per quarter.</p> <p>You choose how to spend the allowance.</p> <p>Pay for services using a flex Mastercard® debit card.</p>	<p>After plan-paid benefits, you are responsible for the remaining costs.</p> <p>Any allowance amount not used by March 31, June 30, or September 30 will not rollover to the next quarter, and expire December 31.</p>
<p>OTC & Herbal Supplemental Flex Allowance</p> <p>This plan provides a combined quarterly allowance of \$75. The annual maximum benefit is \$300</p> <p>Over-the-Counter items (OTC) include, but are not limited to:</p> <ul style="list-style-type: none"> • Pain medication • Cold & flu medicine • First aid supplies <p>Herbal Supplements include, but are not limited to:</p> <ul style="list-style-type: none"> • Ginseng • Bird's Nest • Tiger balm 	<p>\$0 copay up to the maximum plan allowance amount, per quarter.</p> <p>You choose how to spend the allowance.</p> <p>Pay for services using a flex Mastercard® debit card.</p>	<p>After plan-paid benefits, you are responsible for the remaining costs.</p> <p>Any allowance amount not used by March 31, June 30, or September 30 will not rollover to the next quarter, and expire December 31.</p> <p>You can purchase OTC items online and at retail locations.</p> <p>Herbal supplements can be purchased from a network supplier or by calling Clever Care. Herbal supplements are used to treat conditions such as inflammation, anxiety, digestive system, and more.</p>
<p>Acupuncture Services (routine)</p> <p>This plan covers unlimited in-network, routine acupuncture services up to \$1,500 every year.</p> <p>Eastern Wellness Services</p> <p>This plan offers a maximum of 18 wellness services per calendar year. Services include:</p> <ul style="list-style-type: none"> • Cupping/Moxa • Tui Na, Gua Sha • Med-X, and Reflexology 	<p>\$0 copay, per visit, up to the plan maximum amount</p> <p>\$0 copay, per visit, up to the maximum allowed visits</p>	<p>You must use a doctor in our acupuncture network.</p> <p>After plan-paid benefits, you are responsible for the remaining costs.</p> <p>Any allowance amount not used will expire December 31.</p>

Benefits	You Pay	Important to Know
Health and Wellness (routine) <ul style="list-style-type: none"> 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.
24-hour Optum® Nurseline Staffed by licensed nurses 24 hours a day, 365 days a year.	\$0 copay per call	Use this benefit to get advice from a licensed nurse when you are not sure where to seek care or have questions about an urgent healthcare event.
Telehealth Visit Visits can take place using your phone, tablet, or computer. <ul style="list-style-type: none"> Teladoc® visit (available 24-hours a day). Visit offered through your physician's office. 	\$0 copay for a medical visit 20% coinsurance for a mental health visit \$0 copay per visit	Teladoc providers can diagnose and treat non-emergent conditions and prescribe medications when necessary.

More benefits included in your plan:

Benefits	You Pay	Important to Know
Worldwide Coverage	\$0 copay	This plan has a \$100,000 annual limit for covered emergency care, urgently needed services, and ambulance rides outside the United States and its territories.
Post-discharge Meal Assistance* Available immediately following an inpatient hospital or a skilled nursing facility stay to help with recovery.	\$0 copay for meal assistance up to 3 meals per day for 28 days; not to exceed 84 meals per year.	Not available after an outpatient surgery visit.
Personal Emergency Response System (PERS)* This plan offers a mobile device and monitoring service to connect you with a 24-hour response center.	\$0 copay per year	

*Service requires a referral and/or prior authorization.

Benefits	You Pay	Important to Know
<p>Special Supplemental Benefits for the Chronically Ill (SSBCI)*</p> <p>If you are diagnosed with any of the chronic condition(s) listed below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.</p> <ul style="list-style-type: none"> • Cardiovascular disorders • Chronic and disabling mental health conditions • Chronic heart failure • Chronic lung disorders • Dementia • Diabetes • End-stage liver disease • End-stage renal disease • HIV/AIDS • Neurologic disorders • Stroke 	<p>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 for members who qualify.</p> <p>Groceries (healthy food) \$0 copay for eligible food items with a \$25 limit per month. Does not rollover to the following month.</p> <p>Telemonitoring Service \$0 copay for a device to monitor medical and other health data.</p> <p>In-home Safety Assessment \$0 copay for up to two assessments per year.</p> <p>In-home Support Services \$0 copay for services to assist with activities of daily living. Limited to 40 hours per year.</p> <p>Social Needs Benefits \$0 copay for companionship services by non-clinical personal caregivers. Services are limited to 24 four-hour shifts (96 total hours).</p> <p>Support for Caregivers \$0 copay for respite care. Limited to 40 hours per year.</p>	<p>The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify.</p> <p>Services will be provided using the plan's contracted vendors.</p>

*Service requires a referral and/or prior authorization.

Your cost-sharing may differ depending on the pharmacy you choose (e.g., standard retail, out-of-network, mail-order) or whether you receive a 30- or 100-day supply. If you live in a long-term care facility (LTC), you pay the same amount as you would at a standard retail pharmacy for a 31-day supply of medication.

Part D prescription drug benefit and what you pay.

Stage 1: Annual Deductible	\$0 This stage does not apply because there is no deductible.			
Stage 2: Initial Coverage You pay the following until the total yearly drug cost (paid by the plan and you) reaches \$5,030.	Standard retail cost-sharing (In-network)		Standard Cost-sharing (Mail Order)	Retail cost-sharing (Out-of-network)*
	30-day supply	100-day supply	100-day supply	30-day supply
Tier 1: Preferred Generic Drugs	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Tier 2: Generic Drugs	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Tier 3: Preferred Brand Drugs	\$47 copay	\$141 copay	\$94 copay	\$47 copay
Tier 4: Non-Preferred Drugs	\$99 copay	\$297 copay	\$198 copay	\$99 copay
Tier 5: Specialty Tier Drugs*	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
Tier 6: Supplemental Drugs**	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Insulin:	You will not pay more than \$35 for a one-month supply of each covered insulin product, regardless of the cost-sharing tier.			

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*A long-term supply of medication is not available at out-of-network pharmacies, or at retail or mail order for select drugs on Tiers 1–6. **Tier 6 supplemental drugs include generic Viagra, prescription cough medicine, and vitamins.

Stage 3: Coverage Gap After the total yearly drug cost reaches \$5,030 you remain in this stage until the total yearly drug cost (paid by the plan and you) reaches \$8,000.	<p>During this stage you pay:</p> <ul style="list-style-type: none"> • \$0 copay for a 30-day supply of Tier 1 and Tier 2 drugs. • \$47 copay for a 30-day supply of select Tier 3 drugs. • 25% of the price for Tier 4 and Tier 5 drugs (plus a portion of the dispensing fee).
Stage 4: Catastrophic Coverage After the total yearly drug cost reaches \$8,000 you will stay in this stage until the end of the calendar year.	During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.



Pre-Enrollment Checklist

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

Understanding the benefits

- 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.

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