

# Clover

## Georgia Green (Plan 026)—2018 Medical Benefits

Effective Date: 1/1/2018 | Version 1.0

Medical Benefit Description	In-Network	Out-of-Network
<b>Part D Deductible</b> For <b>Part D Copay</b> information, see page 26.	<b>\$100/year</b> for Part D prescription drugs Tiers 1 and 2 are not subject to the deductible.	<b>\$100/year</b> for Part D prescription drugs Tiers 1 and 2 are not subject to the deductible.
<b>Out-of-Pocket Max</b>	<b>\$6,700/year</b> Does not include prescription drugs or supplemental benefits.	<b>\$6,700/year</b> Does not include prescription drugs or supplemental benefits.
<b>Counties</b>	Chatham	Chatham
<b>INPATIENT CARE</b>		
<b>Inpatient Hospital Care</b> Includes Substance Abuse and Rehabilitation Services  *May require prior authorization	<b>\$220 copay/day</b> Days 1–6  <b>\$0 copay/day</b> Days 7–365  Copay applies per stay.	<b>25%</b> of the cost for each hospital stay
<b>Inpatient Mental Health Care</b>  *May require prior authorization	<b>\$220 copay/day</b> Days 1–6  <b>\$0 copay/day</b> Days 7–365  Copay applies per stay.	<b>25%</b> of the cost for each hospital stay

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Medical Benefit Description	In-Network	Out-of-Network
<b>INPATIENT CARE</b> <i>(continued)</i>		
<p><b>Skilled Nursing Facility</b> In a Medicare-certified skilled nursing facility</p> <p>*May require prior authorization</p>	<p><b>\$0</b> copay/day Days 1–20</p> <p><b>\$145</b> copay/day Days 21–100</p> <p>No prior hospital stay is required. Member is covered for 100 days/benefit period.</p>	<p><b>35%</b> of the cost for each skilled nursing facility stay</p> <p>No prior hospital stay is required. Member is covered for 100 days/benefit period.</p>
<p><b>Inpatient Ancillary Services</b></p>	<p><b>\$0</b></p>	<p><b>\$0</b></p>
<p><b>Hospice</b></p>	<p>Member must receive care from a Medicare-certified Hospice. When enrolled in a hospice program, hospice services and Part A and Part B services related to the terminal prognosis are paid for by Original Medicare, not Clover Health.</p> <p>Clover Health will pay for a consultative visit before selecting a hospice.</p>	<p>Member must receive care from a Medicare-certified Hospice. When enrolled in a hospice program, hospice services and Part A and Part B services related to the terminal prognosis are paid for by Original Medicare, not Clover Health.</p> <p>Clover Health will pay for a consultative visit before selecting a hospice.</p>

Medical Benefit Description	In-Network	Out-of-Network
<b>OUTPATIENT CARE</b>		
<p><b>Physician Services</b> Including doctor office visits for illness/injury</p>	<p><b>\$0</b> for each primary care office visit and Outpatient Medical Procedures by a PCP</p> <p><b>\$30</b> for each specialist office visit and Outpatient Medical Procedures by a Specialist</p> <p><b>Clover recognized PCPs:</b> Family Practice, General Practice, Internal Medicine, OB-GYN, Geriatric Medicine.</p> <p>Copay is taken on facility claim, not the professional claim, if applicable.</p>	<p><b>35%</b> of the cost for each primary care office visit and Outpatient Medical Procedures by a PCP</p> <p><b>35%</b> of the cost for each specialist office visit and other Outpatient Medical Procedures by a Specialist</p> <p><b>Clover recognized PCPs:</b> Family Practice, General Practice, Internal Medicine, OB-GYN, Geriatric Medicine.</p> <p>Coinsurance is taken on the both facility claim and the professional claim, if applicable.</p>
<p><b>Home Health Care</b> Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.</p> <p>*May require prior authorization</p>	<p><b>\$0</b> for all Medicare covered home health visits and home therapy sessions</p>	<p><b>35%</b> of the cost for all Medicare covered home health visits and home therapy sessions</p>
<p><b>Chiropractic Services</b></p>	<p><b>\$20</b> for each Medicare covered chiropractic service (manual manipulation of the spine to correct subluxation).</p> <p>Limit to 25 visits/year.</p> <p>No coverage for routine chiropractic services.</p>	<p><b>35%</b> of the cost for each Medicare covered chiropractic service (manual manipulation of the spine to correct subluxation).</p> <p>Limit to 25 visits/year.</p> <p>No coverage for routine chiropractic services.</p>

Medical Benefit Description	In-Network	Out-of-Network
<b>OUTPATIENT CARE</b> <i>(continued)</i>		
<p><b>Podiatry Services</b></p>	<p><b>\$30</b> for each Medicare covered podiatry visit and podiatry surgery</p> <p>No coverage for routine podiatry services.</p>	<p><b>35%</b> of the cost for each Medicare covered podiatry visit and podiatry surgery</p> <p>No coverage for routine podiatry services.</p>
<p><b>Outpatient Rehabilitation Services</b></p> <p>You pay per visit.</p> <p>*May require prior authorization</p>	<p><b>\$30</b> for each Medicare covered Physical Therapy session</p> <p>Limit to \$2,010 per year combined with Speech Therapy.</p> <p><b>\$30</b> for each Medicare covered Occupational Therapy session</p> <p>Limit to \$2,010 per year.</p> <p><b>\$30</b> for each Medicare covered Speech/Language Therapy session</p> <p>Limit to \$2,010 per year combined with Physical Therapy.</p> <p><b>\$30</b> for each Medicare covered Cardiac Rehab session, Intensive Cardiac Rehab service, Pulmonary Rehab session, and for other Medicare covered therapy sessions</p> <p><b>Cardiac Rehab:</b> Limit to 36 sessions per year. <b>Intensive Cardiac Rehab:</b> Limit to 72 sessions per year. <b>Pulmonary Rehab:</b> Limit to 36 sessions per year.</p>	<p><b>35%</b> of the cost for each Medicare covered Physical Therapy session</p> <p>Limit to \$2,010 per year combined with Speech Therapy.</p> <p><b>35%</b> of the cost for each Medicare covered Occupational Therapy session</p> <p>Limit to \$2,010 per year.</p> <p><b>35%</b> of the cost for each Medicare covered Speech/ Language Therapy session</p> <p>Limit to \$2,010 per year combined with Physical Therapy.</p> <p><b>35%</b> of the cost for each Medicare covered Cardiac Rehab session, Intensive Cardiac Rehab service, Pulmonary Rehab session, and for other Medicare covered therapy sessions</p> <p><b>Cardiac Rehab:</b> Limit to 36 sessions per year. <b>Intensive Cardiac Rehab:</b> Limit to 72 sessions per year. <b>Pulmonary Rehab:</b> Limit to 36 sessions per year.</p>

Medical Benefit Description	In-Network	Out-of-Network
<b>OUTPATIENT CARE</b> <i>(continued)</i>		
<p><b>Outpatient Mental Health</b> Including Partial Hospitalization</p> <p>*May require prior authorization</p>	<p><b>\$30</b> for each Medicare covered individual therapy visit, group therapy visit, and mental health services</p> <p><b>\$30</b> for each Medicare covered individual therapy visit with a psychiatrist, group therapy visit with a psychiatrist, and mental health services with a psychiatrist</p> <p><b>\$30</b> per day for Medicare covered partial hospitalization program services</p>	<p><b>35%</b> of the cost for each Medicare covered individual therapy visit, group therapy visit, and mental health services</p> <p><b>35%</b> of the cost for each Medicare covered individual therapy visit with a psychiatrist, group therapy visit with a psychiatrist, and mental health services with a psychiatrist</p> <p><b>35%</b> of the cost per day for Medicare covered partial hospitalization program services</p>
<p><b>Outpatient Observation</b></p>	<p><b>\$0</b> if admitted to inpatient from observation; inpatient R&amp;B copay will apply</p> <p><b>\$75</b> if admitted to observation through ER</p> <p><b>\$290</b> if observation leads to surgery</p> <p><b>\$75</b> if discharged home from observation</p>	<p><b>\$0</b> if admitted to inpatient from observation; inpatient R&amp;B coinsurance will apply</p> <p><b>35%</b> of the cost if admitted to observation through ER</p> <p><b>35%</b> of the cost if observation leads to surgery</p> <p><b>35%</b> of the cost if discharged home from observation</p>
<p><b>Outpatient Substance Abuse Care</b></p> <p>*May require prior authorization</p>	<p><b>\$30</b> for each Medicare covered substance abuse service (with or without a psychiatrist)</p>	<p><b>35%</b> of the cost for each Medicare covered substance abuse service (with or without a psychiatrist)</p>

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<b>OUTPATIENT CARE</b> <i>(continued)</i>		
<b>Ambulatory Surgery</b> *May require prior authorization	<b>\$200</b> for each Medicare covered visit to an ambulatory surgical center	<b>35%</b> of the cost for each Medicare covered visit to an ambulatory surgical center
<b>Outpatient Surgery &amp; Supplies</b> *May require prior authorization	<b>\$290</b> for each Medicare covered visit to an outpatient hospital facility  <b>\$0</b> for each Medicare covered visit in an office setting by a PCP, except for diagnostic colonoscopy (see Diagnostic Colonoscopy category)  <b>\$30</b> for each Medicare covered visit in an office setting by a Specialist, except for diagnostic colonoscopy (see Diagnostic Colonoscopy category)	<b>35%</b> of the cost for each Medicare covered visit to an outpatient hospital facility  <b>35%</b> of the cost for each Medicare covered visit in an office setting by a PCP  <b>35%</b> of the cost for each Medicare covered visit in an office setting by a Specialist
<b>Anesthesia</b>	<b>\$0</b> for each Medicare covered anesthesia service	<b>35%</b> of the cost for each Medicare covered anesthesia service
<b>Ambulance Services</b> Medically necessary ambulance services  *May require prior authorization	<b>\$300/one-way trip</b> for Medicare covered ambulance transports  Copay will not be waived if admitted to the hospital.	<b>\$300/one-way trip</b> for Medicare covered ambulance transports  Copay will not be waived if admitted to the hospital.

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Medical Benefit Description	In-Network	Out-of-Network
<b>OUTPATIENT CARE</b> <i>(continued)</i>		
<p><b>Emergency Care</b> You may go to any emergency room if you reasonably believe you need emergency care</p>	<p><b>\$75</b> for each visit to an Emergency Room</p> <p><b>\$0</b> for emergency room visit if admitted to the hospital</p> <p>Plan does not offer World Wide Coverage.</p>	<p><b>\$75</b> for each visit to an Emergency Room</p> <p><b>\$0</b> for emergency room visit if admitted to the hospital</p> <p>Plan does not offer World Wide Coverage.</p>
<p><b>Urgently Needed Care</b> This is NOT emergency care.</p>	<p><b>\$30</b> of the cost for Medicare covered Urgent Needed Care Visit</p> <p><b>\$0</b> for urgently needed care visit if admitted to the hospital</p>	<p><b>\$30</b> of the cost for Medicare covered Urgent Needed Care Visit</p> <p><b>\$0</b> for urgently needed care visit if admitted to the hospital</p>
<p><b>Durable Medical Equipment (DME) &amp; Supplies</b> Includes wheelchairs, oxygen, etc.</p> <p>*May require prior authorization</p>	<p><b>20%</b> of the cost for each Medicare covered item</p>	<p><b>20%</b> of the cost for each Medicare covered item</p>
<p><b>Prosthetic &amp; Orthotic Devices</b> Includes braces, artificial limbs and eyes, etc.</p> <p>*May require prior authorization</p>	<p><b>20%</b> of the cost for each Medicare covered prosthetic device or orthotic device</p>	<p><b>20%</b> of the cost for each Medicare covered prosthetic device or orthotic device</p>

Medical Benefit Description	In-Network	Out-of-Network
<b>OUTPATIENT CARE</b> <i>(continued)</i>		
<p><b>Diabetes Self-Monitoring Training and Supplies</b> Includes coverage for glucose monitors, test strips, lancets, screening tests, and self management training</p>	<p><b>\$0</b> for Medicare covered Diabetes self-management training</p> <p><b>Initial Year:</b> up to 10 hours of training within a continuous 12-month period</p> <p><b>Subsequent Year:</b> up to 2 hours of training each year after the initial year</p> <p><b>35%</b> of the cost for Medicare-covered Diabetes monitors or strips with HCPCS codes A4253, E0607, E2100, E2101 from a DME supplier</p> <p><b>\$0</b> for all other Medicare-covered Diabetes supplies from a DME supplier</p> <p><b>\$0</b> for Johnson &amp; Johnson One-Touch Test Strips &amp; monitors and Roche Diagnostics Accu-Chek Test Strips &amp; monitors when obtained from an in-network pharmacy</p> <p><b>\$0</b> for Medicare covered therapeutic shoes or inserts</p> <p>Limit to 1 pair of diabetic shoes per year. Limit to 3 pairs of diabetic shoe inserts per year.</p>	<p><b>35%</b> of the cost for Medicare covered Diabetes self-management training</p> <p><b>Initial Year:</b> up to 10 hours of training within a continuous 12-month period</p> <p><b>Subsequent Year:</b> up to 2 hours of training each year after the initial year</p> <p><b>35%</b> of the cost for each Medicare covered Diabetes monitors or strips from a DME supplier</p> <p><b>35%</b> of the cost for all other Medicare-covered Diabetes supplies from a DME supplier</p> <p><b>35%</b> of the cost for Medicare covered therapeutic shoes or inserts</p> <p>Limit to 1 pair of diabetic shoes per year. Limit to 3 pairs of diabetic shoe inserts per year.</p>



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Medical Benefit Description	In-Network	Out-of-Network
<b>OUTPATIENT CARE</b> <i>(continued)</i>		
<b>If a member receives multiple diagnostic tests and therapeutic services (e.g. labs, X-rays, and radiation) at the same location on the same day, only the maximum cost share applies.</b>		
<b>Clinical/Diagnostic Labs</b> *May require prior authorization	<b>Up to \$10</b> for Medicare-covered clinical/diagnostic lab or pathology service  <b>\$0</b> for venipuncture, transportation, and set up of lab equipment	<b>35%</b> of the cost for Medicare-covered clinical/diagnostic lab or pathology service  <b>\$0</b> for venipuncture, transportation, and set up of lab equipment
<b>Radiation Therapy</b> *May require prior authorization	<b>Up to \$60</b> for each radiation therapy service	<b>35%</b> of the cost for each radiation therapy service
<b>Radiology/X-Rays</b>	<b>Up to \$30</b> for each General Radiology/X-ray service  <b>\$0</b> for the transportation & set up of X-Ray equipment	<b>35%</b> of the cost for each General Radiology/X-ray service  <b>\$0</b> for the transportation & set up of X-Ray equipment
<b>Advanced Radiology</b> Including MRA, MRI, Nuclear Med, PET scans, & CAT Scans *May require prior authorization	<b>Up to \$225</b> for Advanced Radiology services  Limit to 1 per lifetime for PET Beta Amyloid Dementia and Neurodegenerative Disease.	<b>35%</b> of the cost for Advanced Radiology services  Limit to 1 per lifetime for PET Beta Amyloid Dementia and Neurodegenerative Disease.
<b>Diagnostic Tests—Allergy</b>	<b>Up to \$10</b> for Allergy services (includes testing and treatment) from a PCP or specialist	<b>35%</b> of the cost for Allergy services (includes testing and treatment) from a PCP or specialist

Medical Benefit Description	In-Network	Out-of-Network
<b>OUTPATIENT CARE</b> <i>(continued)</i>		
<b>If a member receives multiple diagnostic tests and therapeutic services (e.g. labs, X-rays, and radiation) at the same location on the same day, only the maximum cost share applies.</b>		
<b>Diagnostic Tests—Cardiology</b> *May require prior authorization	<b>Up to \$150</b> for each Cardiology service in an outpatient setting  <b>Up to \$50</b> for each Cardiology service in an office setting	<b>35%</b> of the cost for each Cardiology service
<b>Diagnostic Tests—Echo</b> *May require prior authorization	<b>Up to \$150</b> for each Echography service in an outpatient setting  <b>Up to \$50</b> for each Echography service in an office setting	<b>35%</b> of the cost for each Echography service
<b>Diagnostic Tests—EEG</b> *May require prior authorization	<b>Up to \$150</b> for each EEG service in an outpatient setting  <b>Up to \$50</b> for each EEG service in an office setting	<b>35%</b> of the cost for each EEG service
<b>Diagnostic Tests—EKG</b>	<b>\$0</b> for each EKG service	<b>35%</b> of the cost for each EKG service
<b>Diagnostic Tests—Gastroenterology</b> *May require prior authorization	<b>Up to \$150</b> for each Gastroenterology service in an outpatient setting  <b>Up to \$50</b> for each Gastroenterology service in an office setting	<b>35%</b> of the cost for each Gastroenterology service

Medical Benefit Description	In-Network	Out-of-Network
<b>OUTPATIENT CARE</b> <i>(continued)</i>		
<b>If a member receives multiple diagnostic tests and therapeutic services (e.g. labs, X-rays, and radiation) at the same location on the same day, only the maximum cost share applies.</b>		
<b>Diagnostic Tests—Other Diagnostic Services</b>  *May require prior authorization	<b>Up to \$150</b> for each Diagnostic service in an outpatient setting  <b>Up to \$50</b> for each Diagnostic service in an office setting	<b>35%</b> of the cost for each Diagnostic service
<b>Diagnostic Tests—Pulmonary</b>  *May require prior authorization	<b>Up to \$150</b> for each Pulmonary service in an outpatient setting  <b>Up to \$50</b> for each Pulmonary service in an office setting	<b>35%</b> of the cost for each Pulmonary service
<b>Diagnostic Tests—Sleep Study</b>  *May require prior authorization	<b>Up to \$150</b> for each Sleep Study service in an outpatient setting  <b>Up to \$50</b> for each Sleep Study service in an office setting	<b>35%</b> of the cost for each Sleep Study service
<b>Diagnostic Tests—Ultrasound</b>	<b>Up to \$150</b> for each Ultrasound service in an outpatient setting  <b>Up to \$50</b> for each Ultrasound service in an office setting	<b>35%</b> of the cost for each Ultrasound service
<b>Diagnostic Tests—Vascular</b>  *May require prior authorization	<b>Up to \$150</b> for each Vascular service in an outpatient setting  <b>Up to \$50</b> for each Vascular service in an office setting	<b>35%</b> of the cost for each Vascular service

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<b>OUTPATIENT CARE</b> <i>(continued)</i>		
<b>If a member receives multiple diagnostic tests and therapeutic services (e.g. labs, X-rays, and radiation) at the same location on the same day, only the maximum cost share applies.</b>		
<b>Diagnostic Colonoscopy</b>  *May require prior authorization	<b>Up to \$290</b> for each Diagnostic Colonoscopy in an outpatient setting  <b>Up to \$200</b> for each Diagnostic Colonoscopy in an office or ASC setting	<b>35%</b> of the cost for each Diagnostic Colonoscopy
<b>Diagnostic Bone Mass Measurement</b>	<b>Up to \$150</b> for each Medicare covered Diagnostic Bone Mass Measurement in an outpatient setting  <b>Up to \$50</b> for each Medicare covered Diagnostic Bone Mass Measurement in an office setting	<b>35%</b> of the cost for each Medicare Covered Diagnostic Bone Mass Measurement
<b>Diagnostic Mammogram</b>	<b>Up to \$150</b> for each Medicare covered Diagnostic Mammogram in an outpatient setting  <b>Up to \$50</b> for each Medicare covered Diagnostic Mammogram in an office setting	<b>35%</b> of the cost for each Medicare Covered Diagnostic Mammogram
<b>Chemotherapy</b>  *May require prior authorization	<b>20%</b> of the cost for each chemotherapy service, chemotherapy drug, and Oncology Service	<b>35%</b> of the cost for each chemotherapy service, chemotherapy drug, and Oncology Service

Medical Benefit Description	In-Network	Out-of-Network
<b>OUTPATIENT CARE</b> <i>(continued)</i>		
<p><b>Surgical Supplies, Splints, and Casts</b></p> <p>*May require prior authorization</p>	<p><b>20%</b> of the cost for surgical supplies, dressings, splints &amp; casts when billed on a 1500 by DME supplier or when billed on a hospital claim</p>	<p><b>20%</b> of the cost for surgical supplies, dressings, splints &amp; casts when billed on a 1500 by DME supplier or when billed on a hospital claim</p>
<p><b>Blood</b></p>	<p>Coverage for blood, storage, and administration begins w/ the 1st pint of blood.</p> <p><b>\$0</b> per unit of blood for Medicare covered benefits</p>	<p>Coverage for blood, storage, and administration begins w/ the 1st pint of blood.</p> <p><b>35%</b> of the cost per unit of blood for Medicare covered benefits</p>
<p><b>Outpatient Part B Drugs &amp; Injectables</b></p> <p>Covered under Medicare Part B</p> <p>*May require prior authorization</p>	<p><b>20%</b> of the cost for outpatient Part B Drugs &amp; Injectables, Infusion Therapy, Nebulizer Drugs, and Imaging Agents</p> <p>Limit of 1 per month for B-12 injection. Limit of 1 per lifetime for PET Beta Amyloid Dementia and Neurodegenerative Disease. Limit of 3 per lifetime for Autogous Cellar Immunotherapy.</p>	<p><b>35%</b> of the cost for outpatient Part B Drugs &amp; Injectables, Infusion Therapy, Nebulizer Drugs, and Imaging Agents</p> <p>Limit of 1 per month for B-12 injection. Limit of 1 per lifetime for PET Beta Amyloid Dementia and Neurodegenerative Disease. Limit of 3 per lifetime for Autogous Cellar Immunotherapy.</p>
<p><b>Renal Dialysis</b></p>	<p><b>20%</b> of the cost for Medicare Covered renal dialysis</p> <p><b>\$0</b> for Medicare Covered kidney disease education services</p> <p><b>20%</b> of the cost for outpatient dialysis services</p> <p>Limit to 6 sessions (individual or group) per lifetime for Kidney Disease</p>	<p><b>35%</b> of the cost for Medicare Covered renal dialysis</p> <p><b>35%</b> of the cost for Medicare Covered kidney disease education services</p> <p><b>35%</b> of the cost for outpatient dialysis services</p> <p>Limit to 6 sessions (individual or group) per lifetime for Kidney Disease Education.</p>

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<b>PREVENTIVE SERVICES</b>		
<b>Abdominal Aortic Aneurysm (AAA) Screening</b>	<b>\$0</b> for each Abdominal Aortic Aneurysm (AAA) screening  Limit to 1 per lifetime.	<b>35%</b> of the cost for each Abdominal Aortic Aneurysm (AAA) screening  Limit to 1 per lifetime.
<b>Alcohol Misuse Screening and Counseling</b>	<b>\$0</b> for each alcohol misuse screening/counseling service  Limit to 1 per year for misuse screening, 15 min. Limit to 4 times per year for brief face-to-face counseling, 15 min.	<b>35%</b> of the cost for each alcohol misuse screening/counseling service  Limit to 1 per year for misuse screening, 15 min. Limit to 4 times per year for brief face-to-face counseling, 15 min.
<b>Annual Wellness Visit (AWV)</b> This is not the IPPE	<b>\$0</b> for the annual wellness visit  Limit to 1 per year.	<b>35%</b> of the cost for the annual wellness visit  Limit to 1 per year.
<b>Bone Mass Measurement Screening</b>	<b>\$0</b> for each Medicare covered Preventive Bone Mass Measurement  Limit to 1 every 24 months.	<b>35%</b> of the cost for each Medicare covered Preventive Bone Mass Measurement  Limit to 1 every 24 months.
<b>Cardiovascular Screening Blood Tests</b>	<b>\$0</b> for each Medicare covered cardiovascular disease screening test  Limit to 1 every 5 years.	<b>35%</b> of the cost for each Medicare covered cardiovascular disease screening test  Limit to 1 every 5 years.

Medical Benefit Description	In-Network	Out-of-Network
<b>PREVENTIVE SERVICES</b> <i>(continued)</i>		
<p><b>Colorectal Cancer Screening Exams</b></p> <p>For people with Medicare age 50 and older &amp; others at high risk regardless of age.</p> <p>Outpatient Surgery copay will apply if there is a surgical procedure during a screening colonoscopy.</p>	<p><b>\$0</b> for each Fecal Occult blood test</p> <p>Limit 1 per year.</p> <p><b>\$0</b> for each Flexible Sigmoidoscopy</p> <p>Limit to 1 every 4 years. (If a screening colonoscopy has been performed, Clover may cover a screening flexible sigmoidoscopy only after 10 years.)</p> <p><b>\$0</b> for each Screening Colonoscopy</p> <p>Limit to 1 every 24 months at high risk. Limit to 1 every 10 years not at high risk. (For any risk, if a screening flexible sigmoidoscopy has been performed Clover may cover a screening colonoscopy only after 4 years.)</p> <p><b>\$0</b> for each Barium Enema</p> <p>Limit to 1 every 24 months at high risk. Limit to 1 every 4 years not at high risk.</p> <p><b>\$0</b> for each Colorectal Cancer Screening with Cologuard</p> <p>Limit to 1 per 3 years.</p>	<p><b>35%</b> of the cost for each Fecal Occult blood test</p> <p>Limit 1 per year.</p> <p><b>35%</b> of the cost for each Flexible Sigmoidoscopy</p> <p>Limit to 1 every 4 years. (If a screening colonoscopy has been performed, Clover may cover a screening flexible sigmoidoscopy only after 10 years.)</p> <p><b>35%</b> of the cost for each Screening Colonoscopy</p> <p>Limit to 1 every 24 months at high risk. Limit to 1 every 10 years not at high risk. (For any risk, if a screening flexible sigmoidoscopy has been performed Clover may cover a screening colonoscopy only after 4 years.)</p> <p><b>35%</b> of the cost for each Barium Enema</p> <p>Limit to 1 every 24 months at high risk. Limit to 1 every 4 years not at high risk.</p> <p><b>35%</b> of the cost for each Colorectal Cancer Screening with Cologuard</p> <p>Limit to 1 per 3 years.</p>

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<b>PREVENTIVE SERVICES</b> <i>(continued)</i>		
<b>Diabetes Screening Test</b>	<p><b>\$0</b> for each Diabetes screening test</p> <p>Limit to 2 per year for beneficiaries diagnosed with pre-diabetes.</p> <p>Limit to 1 screening per year if previously tested but not diagnosed with pre-diabetes, or if never tested.</p>	<p><b>35%</b> of the cost for each Diabetes screening test</p> <p>Limit to 2 per year for beneficiaries diagnosed with pre-diabetes.</p> <p>Limit to 1 screening per year if previously tested but not diagnosed with pre-diabetes, or if never tested.</p>
<b>Glaucoma Screening</b>	<p><b>\$0</b> for each Medicare covered Glaucoma screening test</p> <p>Limit to 1 per year.</p>	<p><b>35%</b> of the cost for each Medicare covered Glaucoma screening test</p> <p>Limit to 1 per year.</p>
<b>Health &amp; Wellness Education Programs</b>	<p><b>\$0</b> for a SilverSneakers® membership</p> <p>To find a fitness center that participates in the SilverSneakers® network, please visit <a href="https://www.silversneakers.com/locations">https://www.silversneakers.com/locations</a></p>	<p>No coverage for non-participating SilverSneakers® fitness centers</p>
<b>Smoking Cessation</b>	<p><b>\$0</b> for each Medicare covered smoking and tobacco use cessation</p> <p>Limit to 2 cessation attempts per year. Each attempt may include a maximum of 4 intermediate or intensive sessions, with the total annual benefit covering up to 8 sessions per year.</p>	<p><b>35%</b> of the cost for each Medicare covered smoking and tobacco use cessation</p> <p>Limit to 2 cessation attempts per year. Each attempt may include a maximum of 4 intermediate or intensive sessions, with the total annual benefit covering up to 8 sessions per year.</p>



Medical Benefit Description	In-Network	Out-of-Network
<b>PREVENTIVE SERVICES</b> <i>(continued)</i>		
<p><b>HIV Screening</b></p>	<p><b>\$0</b> for each voluntary HIV screening</p> <p>Limit to 1 per year.</p> <p>Limit to 3 per year when pregnant: (1) when the diagnosis of pregnancy is known (2) during the third trimester, and/or (3) at labor if ordered by the physician</p>	<p><b>35%</b> of the cost for each voluntary HIV screening</p> <p>Limit to 1 per year.</p> <p>Limit to 3 per year when pregnant: (1) when the diagnosis of pregnancy is known (2) during the third trimester, and/or (3) at labor if ordered by the physician</p>
<p><b>Immunizations</b></p> <p>Flu vaccine, Hepatitis B vaccine &amp; Pneumonia vaccine</p>	<p><b>\$0</b> for the administration of each vaccine, for each Medicare covered Flu vaccine, Pneumonia vaccine, Hepatitis B vaccine, and other covered immunizations</p> <p>Limit to 2 Flu vaccines per year. Limit to 2 Pneumonia vaccines per lifetime.</p>	<p><b>35%</b> of the cost for the administration of each vaccine, for each Medicare covered Flu vaccine, Pneumonia vaccine, Hepatitis B vaccine, and other covered immunizations</p> <p>Limit to 2 Flu vaccines per year. Limit to 2 Pneumonia vaccines per lifetime.</p>
<p><b>Initial Preventive Physical Exam</b></p> <p>Also known as the “Welcome to Medicare Preventive Visit”</p>	<p><b>\$0</b> for the physical exam</p> <p>Limit to 1 per lifetime. Must be furnished no later than 12 months after the effective date of the first Medicare Part B Coverage.</p>	<p><b>35%</b> of the cost for the physical exam</p> <p>Limit to 1 per lifetime. Must be furnished no later than 12 months after the effective date of the first Medicare Part B Coverage.</p>

# Georgia Green (Plan 026)—2018 Medical Benefits

Effective Date: 1/1/2018 | Version 1.0

Medical Benefit Description	In-Network	Out-of-Network
<b>PREVENTIVE SERVICES</b> <i>(continued)</i>		
<p><b>Intensive Behavioral Therapy</b></p>	<p><b>\$0</b> for each IBT for cardiovascular disease</p> <p>Limit of 1 per year.</p> <p><b>\$0</b> for each IBT for obesity service</p> <p>Limit of 22 per year.</p>	<p><b>35%</b> of the cost for each IBT for cardiovascular disease</p> <p>Limit of 1 per year.</p> <p><b>35%</b> of the cost for each IBT for obesity service</p> <p>Limit of 22 per year.</p>
<p><b>Lung Cancer Screening Counseling and Annual Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)</b></p>	<p><b>\$0</b> for each Lung Cancer Screening Counseling</p> <p><b>\$0</b> for each Lung Cancer Screening w/LDCT</p> <p>Limit of 1 per 12 months.</p>	<p><b>35%</b> of the cost for each Lung Cancer Screening Counseling</p> <p><b>35%</b> of the cost for each Lung Cancer Screening w/LDCT</p> <p>Limit of 1 per 12 months.</p>
<p><b>Screening Mammograms</b></p>	<p><b>\$0</b> for each Medicare covered baseline mammogram</p> <p>Limit to 1 baseline mammogram for women between the ages of 35–39.</p> <p><b>\$0</b> for each Medicare covered screening mammogram</p> <p>Limit to 1 screening mammogram every 12 months for women over 40.</p>	<p><b>35%</b> of the cost for each Medicare covered baseline mammogram</p> <p>Limit to 1 baseline mammogram for women between the ages of 35–39.</p> <p><b>35%</b> of the cost for each Medicare covered screening mammogram</p> <p>Limit to 1 screening mammogram every 12 months for women over 40.</p>

# Georgia Green (Plan 026)—2018 Medical Benefits

Effective Date: 1/1/2018 | Version 1.0

Medical Benefit Description	In-Network	Out-of-Network
<b>PREVENTIVE SERVICES</b> <i>(continued)</i>		
<p><b>Medical Nutrition Therapy (MNT)</b> For people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by a doctor</p>	<p><b>\$0</b> for each Medicare covered Medical Nutrition Therapy visit/service</p> <p>Limit to 3 hours of one-on-one counseling in the 1st year, and 2 hours for each subsequent year.</p>	<p><b>35%</b> of the cost for each Medicare covered Medical Nutrition Therapy visit/service</p> <p>Limit to 3 hours of one-on-one counseling in the 1st year, and 2 hours for each subsequent year.</p>
<p><b>Pap Smears and Pelvic Exams</b></p>	<p><b>\$0</b> for each Medicare covered pap smear and for each Medicare covered pelvic &amp; breast exam</p> <p>Limit to 1 screening pap and 1 pelvic exam every 12 months for women at high risk or at childbearing age w/ abnormal pap in the past 3 years.</p> <p>Limit to 1 screening pap and 1 pelvic exam every 24 months for all other women.</p>	<p><b>35%</b> of the cost for each Medicare covered pap smear and for each Medicare covered pelvic &amp; breast exam</p> <p>Limit to 1 screening pap and 1 pelvic exam every 12 months for women at high risk or at childbearing age w/ abnormal pap in the past 3 years.</p> <p>Limit to 1 screening pap and 1 pelvic exam every 24 months for all other women.</p>
<p><b>Prostate Cancer Screening Exams</b> For men with Medicare age 50 and older</p>	<p><b>\$0</b> for each Medicare covered digital rectal exam (DRE) and for each Medicare covered prostate specific antigen test (PSA)</p> <p>Limit to 1 DRE every 12 months. Limit to 1 PSA every 12 months.</p>	<p><b>35%</b> of the cost for each Medicare covered digital rectal exam (DRE) and for each Medicare covered prostate specific antigen test (PSA)</p> <p>Limit to 1 DRE every 12 months. Limit to 1 PSA every 12 months.</p>
<p><b>Routine Physical Exams</b> This is not the IPPE.</p>	<p>No coverage for routine physical exams.</p>	<p>No coverage for routine physical exams.</p>

Medical Benefit Description	In-Network	Out-of-Network
<b>PREVENTIVE SERVICES</b> <i>(continued)</i>		
<b>Screening for Cervical Cancer with Human Papillomavirus (HPV) Tests</b>	<b>\$0</b> for each cervical cancer screening with human papillomavirus (HPV) tests Limit to 1 every 5 years.	<b>35%</b> of the cost for each cervical cancer screening with human papillomavirus (HPV) tests Limit to 1 every 5 years.
<b>Screening for Depression</b>	<b>\$0</b> for each depression screening service Limit to 1 per year, 15 min.	<b>35%</b> of the cost for each depression screening service Limit to 1 per year, 15 min.
<b>Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs</b>	<b>\$0</b> for each STI/HIBC service <b>Coverage for chlamydia, gonorrhea, syphilis, and Hepatitis B only:</b> Limit to 1 screening per year for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant. Limit to 1 screening per year for syphilis in men at increased risk. Limit up to 2 screenings per pregnancy for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening. Limit to 1 screening per pregnancy for syphilis in pregnant women; up to 2 additional screenings in the third trimester and at delivery if at continued increased risk for STIs. Limit to 1 screening per pregnancy for hepatitis B in pregnant women; 1 additional screening at delivery if at continued increased risk for STIs. Limit up to 2 face-to-face, 20–30 minute, HIBC sessions per year.	<b>\$0</b> for each STI/HIBC service <b>Coverage for chlamydia, gonorrhea, syphilis, and Hepatitis B only:</b> Limit to 1 screening per year for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant. Limit to 1 screening per year for syphilis in men at increased risk. Limit up to 2 screenings per pregnancy for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening. Limit to 1 screening per pregnancy for syphilis in pregnant women; up to 2 additional screenings in the third trimester and at delivery if at continued increased risk for STIs. Limit to 1 screening per pregnancy for hepatitis B in pregnant women; 1 additional screening at delivery if at continued increased risk for STIs. Limit up to 2 face-to-face, 20–30 minute, HIBC sessions per year.

# Georgia Green (Plan 026)—2018 Medical Benefits

Effective Date: 1/1/2018 | Version 1.0

Medical Benefit Description	In-Network	Out-of-Network
<b>PREVENTIVE SERVICES</b> <i>(continued)</i>		
<b>Hepatitis C Virus Screening</b>	<b>\$0</b> for each Hepatitis C screening  Limit to 1 per lifetime or 1 per year depending on diagnosis code.	<b>35%</b> of the cost for each Hepatitis C screening  Limit to 1 per lifetime or 1 per year depending on diagnosis code.
<b>Medicare Diabetes Prevention Program (MDPP)</b> Effective 4/1/2018	<b>\$0</b> for each MDPP session  Limit to 1 year of core and core maintenance sessions followed by up to 1 year of ongoing maintenance sessions. Member must meet weight loss and attendance goals.	<b>35%</b> of the cost for each MDPP session  Limit to 1 year of core and core maintenance sessions followed by up to 1 year of ongoing maintenance sessions. Member must meet weight loss and attendance goals.

Medical Benefit Description	In-Network	Out-of-Network
<b>ADDITIONAL SERVICES</b>		
<p><b>Dental Services</b></p>	<p><b>\$0</b> for each Medicare covered Dental service</p> <p><b>\$0</b> for each Non-Medicare covered Preventive Dental service when received from a DentaQuest provider.</p> <p>Limit 2 preventive exams per year. Limit 2 preventive cleanings per year. Limit 1 preventive x-ray per year.</p> <p>Contracted rates apply for services from non-participating DentaQuest providers.</p> <p>For more information, call Clover Provider Services at 1-877-853-8019 or DentaQuest Provider Services at 800-516-0124. To find a provider visit <a href="http://www.dentaquest.com/find-a-provider/cloverdental">www.dentaquest.com/find-a-provider/cloverdental</a></p> <p>No coverage for Comprehensive Dental services.</p>	<p><b>25%</b> of the cost for each Medicare-covered Dental service</p> <p><b>\$0</b> for each Non-Medicare covered Preventive Dental service when received from a DentaQuest provider.</p> <p>Limit 2 preventive exams per year. Limit 2 preventive cleanings per year. Limit 1 preventive x-ray per year.</p> <p>Contracted rates apply for services from non-participating DentaQuest providers.</p> <p>For more information, call Clover Provider Services at 1-877-853-8019 or DentaQuest Provider Services at 800-516-0124. To find a provider visit <a href="http://www.dentaquest.com/find-a-provider/cloverdental">www.dentaquest.com/find-a-provider/cloverdental</a></p> <p>No coverage for Comprehensive Dental services.</p>

Medical Benefit Description	In-Network	Out-of-Network
<b>ADDITIONAL SERVICES</b> <i>(continued)</i>		
<p><b>Hearing Services</b></p>	<p><b>\$30</b> for each Medicare covered diagnostic hearing exam and each Medicare covered audiology service</p> <p><b>\$0</b> for a Non-Medicare covered routine hearing exam from a TruHearing provider</p> <p>Limit to 1 routine hearing exam per year.</p> <p><b>\$699</b> for each Flyte Advanced hearing aid from a TruHearing provider</p> <p><b>\$999</b> for each Flyte Premium hearing aid from a TruHearing provider</p> <p>Limit to 2 hearing aids per year; 1 per ear per year. 3 hearing aid fittings/evaluation visits are included as part of hearing aid purchase.</p>	<p><b>35%</b> of the cost for each Medicare covered diagnostic hearing exam and each Medicare covered audiology service</p> <p>No coverage for routine hearing exam, hearing aid, and hearing aid fitting/evaluation.</p>

Medical Benefit Description	In-Network	Out-of-Network
<b>ADDITIONAL SERVICES</b> <i>(continued)</i>		
<p><b>Vision Services</b></p>	<p><b>\$30</b> for Medicare covered diagnostic exams to diagnose and treat diseases and conditions of the eye. Refraction is covered and will take applicable copay if performed as a stand-alone service.</p> <p><b>\$0</b> for Medicare covered post-cataract surgery eyewear.</p> <p>Limit to 1 pair of glasses or contacts after each cataract surgery.</p> <p><b>\$0</b> for a Non-Medicare covered routine eye exam (includes refraction) when seen by an EyeQuest provider.</p> <p>Limit to 1 routine eye exam/year.</p> <p><b>\$150 allowance</b> for supplemental eyewear (frames, lenses and/or contact lenses) per year.</p>	<p><b>35%</b> of the cost for Medicare covered diagnostic exams to diagnose and treat diseases and conditions of the eye. Refraction is covered and will take applicable coinsurance if performed as a stand-alone service.</p> <p><b>20%</b> of the cost for Medicare covered post-cataract surgery eyewear.</p> <p>Limit to 1 pair of glasses or contacts after each cataract surgery.</p> <p><b>\$0</b> for a Non-Medicare covered routine eye exam (includes refraction) when seen by an EyeQuest provider.</p> <p>Limit to 1 routine eye exam/year.</p> <p><b>\$150 allowance</b> for supplemental eyewear (frames, lenses and/or contact lenses) per year.</p>



Medical Benefit Description	In-Network	Out-of-Network
<b>NON-COVERED BENEFITS</b>		
<b>Miscellaneous Non Plan Covered Services</b>	<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Athletic Training</li> <li>• Cosmetic Dermatology</li> <li>• Routine Transportation without preauthorization</li> <li>• Self Administered Drugs (SADS)</li> <li>• Miscellaneous non-covered Items</li> <li>• Bundled Services</li> <li>• Demonstration Projects</li> <li>• Billing Errors</li> <li>• Non Medically Necessary Services</li> <li>• Report Only Codes</li> </ul>	<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Athletic Training</li> <li>• Cosmetic Dermatology</li> <li>• Routine Transportation without preauthorization</li> <li>• Self Administered Drugs (SADS)</li> <li>• Miscellaneous non-covered Items</li> <li>• Bundled Services</li> <li>• Demonstration Projects</li> <li>• Billing Errors</li> <li>• Non Medically Necessary Services</li> <li>• Report Only Codes</li> </ul>

Georgia Green (Plan 026)

Tiers	30 Day Supply		60 Day Supply		100 Day Supply		CVS Mail
	Preferred Pharmacy Network	Non-Preferred Pharmacy Network	Preferred Pharmacy Network	Non-Preferred Pharmacy Network	Preferred Pharmacy Network	Non-Preferred Pharmacy Network	CVS Mail Order (100 Day Supply)
Tier 1	\$0	\$5	\$0	\$10	\$0	\$15	\$0
Tier 2	\$10	\$15	\$20	\$30	\$30	\$45	\$20
Tier 3	\$35	\$45	\$70	\$90	\$105	\$135	\$70
Tier 4	\$85	\$95	\$170	\$190	\$255	\$285	\$170
Tier 5	30%	30%	30%	30%	30%	30%	30%

Rx deductible \$100. Deductible applies to tiers 3, 4, & 5. Tiers 1 & 2 are exempt from deductible. **Service Area:** Chatham

Stage 1 Annual Deductible	Stage 2 Initial Coverage	Stage 3 Coverage Gap	Stage 4 Catastrophic
Member pays the full cost of drugs on until the deductible is met. Once met, the member moves to Stage 2.	Member pays a copayment or coinsurance and Clover pays our share of the cost for each prescription filled. Once the combined total cost paid by the member and Clover reaches the \$3,750, the member enters Stage 3.	Member pays 44% of the plan's contracted cost for generic drugs and 35% for brand name drugs. Once the Members True Out-Of-Pocket (TrOOP) cost reaches \$5,000, the member moves to Stage 4.	Member pays a reduced copayment of \$3.35 for generic or \$8.35 for brand name drugs (or 5% of the drug cost— whichever is greater). Member stays in this stage for the remainder of the plan year.