

2020 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

Clover Health Choice (PPO) (Plan 026)

January 1, 2020 – December 31, 2020

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the “**Evidence of Coverage.**”

Sections in this booklet

- Things to Know About **Clover Health Choice (PPO)**.
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document may be available in a non-English language. For additional information, call us at 1-888-657-1207 (TTY: 711).

Things to Know About Clover Health Choice (PPO)

Hours of Operation & Contact Information

- From October 1 to March 31 we're open 8 a.m. – 8 p.m. local time, 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m. local time, Monday through Friday, alternate technologies (for example, voicemail) will be used on the weekends and holidays. If you are a member of this plan, call us at 1-888-657-1207, TTY: 711.
- If you are a member of this plan, call us at 1-888-657-1207, TTY: 711.
- If you are not a member of this plan, call us at 1-888-466-5044, TTY: 711.
- Our website: www.cloverhealth.com.

Who can join?

To join **Clover Health Choice (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and must live in our service area. Our service area includes these counties in Georgia: Bryan, Bulloch, Chatham, Effingham and Liberty.

What do we cover?

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits. Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.cloverhealth.com.
- Or, call us and we will send you a copy of the formulary.

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Deductible Stage, Initial Coverage, Coverage Gap and Catastrophic Coverage.

**If you have any questions about this plan's benefits or costs, please contact
Clover Health**

SECTION II - SUMMARY OF BENEFITS

Clover Health Choice (PPO) (Plan 026)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

Monthly Plan Premium	You do not pay a separate monthly plan premium for Clover Health Choice (PPO). You must continue to pay your Medicare Part B premium.
Deductible	Medical Deductible: Not Applicable. Prescription Drugs Deductible: Not Applicable.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: <ul style="list-style-type: none">• \$6,700 for services you receive from in-network providers.• \$6,700 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. The amount you pay for some services does not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Evidence of Coverage (EOC). Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

COVERED MEDICAL AND HOSPITAL BENEFITS

Covered services that need approval in advance are marked in bold in the Benefits Chart below.

Inpatient Hospital	<u>In-Network:</u> Days 1-6: \$270 Copay per day. Days 7-365: \$0 Copay per day. <u>Out-of-Network:</u> Days 1-6: \$270 Copay per day. Days 7-365: \$0 Copay per day.
Outpatient Hospital	<u>In-Network:</u> Outpatient surgery: \$275 copay. Surgery copay will be waived if there is a surgical procedure during a screening colonoscopy. <u>Out-of-Network:</u> Outpatient surgery: \$275 copay. Surgery copay will be waived if there is a surgical procedure during a screening colonoscopy.

SECTION II - SUMMARY OF BENEFITS

Clover Health Choice (PPO) (Plan 026)

Doctor's Office Visits	<p><u>In-Network:</u> Primary care physician visit: \$0 Copay. Specialist visit: \$15 Copay.</p> <p><u>Out-of-Network:</u> Primary care physician visit: \$0 Copay. Specialist visit: \$15 Copay.</p>
Preventive Care (e.g., flu vaccine, diabetic screenings)	<p><u>In-Network:</u> \$0 Copay for all preventive services covered under Original Medicare.</p> <p><u>Out-of-Network:</u> \$0 Copay for all preventive services covered under Original Medicare.</p> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>
Emergency Care	<p><u>In-Network and Out-of-Network:</u> \$90 Copay per visit. Worldwide Coverage: \$90 Copay per visit. Copay is waived if you are admitted to the hospital within 24 hours. Plan covers up to \$25,000 per calendar year for worldwide emergency care, urgent care, and ambulance services. Applicable copays apply.</p>
Urgently Needed Services	<p><u>In-Network and Out-of-Network:</u> \$25 Copay per visit. Worldwide Coverage: \$25 Copay per visit. Copay is waived if you are admitted to the hospital within 24 hours. Plan covers up to \$25,000 per calendar year for worldwide emergency care, urgent care, and ambulance services. Applicable copays apply.</p>
Diagnostic Services / Labs/ Imaging	<p><u>In-Network:</u> Diagnostic tests and procedures - Office setting or imaging center: \$40 copay</p>

SECTION II - SUMMARY OF BENEFITS

Clover Health Choice (PPO) (Plan 026)

	<p>Diagnostic tests and procedures - Outpatient facility: \$150 copay</p> <p>Labs services: \$0 copay</p> <p>Advanced Radiology (such as MRI, PET, CT, Nuclear medicine) - office setting or imaging center: \$205 copay</p> <p>Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine) - outpatient facility: \$205 copay</p> <p>X-rays services: \$10 copay</p> <p>Therapeutic radiology (radiation): 20% coinsurance</p> <p><u>Out-of-Network:</u></p> <p>Diagnostic tests and procedures - Office setting or imaging center: \$40 copay</p> <p>Diagnostic tests and procedures - Outpatient facility: \$150 copay</p> <p>Labs services: \$0 copay</p> <p>Advanced Radiology (such as MRI, PET, CT, Nuclear medicine) - office setting or imaging center: \$205 copay</p> <p>Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine) - outpatient facility: \$205 copay</p> <p>X-rays services: \$10 copay</p> <p>Therapeutic radiology (radiation): 20% coinsurance</p>
Hearing Services	<p><u>In-Network:</u></p> <p>Medicare-covered diagnostic hearing exam: \$15 copay</p> <p>Routine hearing exam (1 per calendar year): \$0 copay</p> <p>Hearing aids (up to 2 aids per calendar year - one per ear per year): \$699 copay for Advanced aids through a TruHearing provider \$999 copay for Premium aids through a TruHearing provider</p> <p><u>Out-of-Network:</u></p> <p>Medicare-covered diagnostic hearing exam: \$15 copay</p> <p>Routine hearing exam (1 calendar year): \$0 copay</p> <p>Hearing aids (up to 2 aids per calendar year - one per ear per year): \$999 copayment per aid</p>

SECTION II - SUMMARY OF BENEFITS

Clover Health Choice (PPO) (Plan 026)

Dental Services

In-Network:

Medicare Covered: \$0 Copay. During an inpatient acute stay if medically necessary. Inpatient hospital copay rules apply.

Preventive dental services:

- Oral exam (at least 1 per calendar year): \$0 Copay.
- Cleaning (for up to 2 per calendar year): \$0 Copay.
- Fluoride treatment (for up to 2 per calendar year): \$0 Copay.
- Dental X-rays (at least 1 per calendar year): \$0 Copay.

Comprehensive dental services:

Plan covers up to \$1000 per calendar year for combined in and out-of-network non-Medicare covered comprehensive dental services after you pay a \$20 copay for each service. Supplemental comprehensive dental services include:

- **Restorative services**
- **Endodontics**
- **Periodontics**
- **Extractions**
- **Prosthodontics, Other Oral/Maxillofacial Surgery, and Other Services**

Out-of-Network:

Medicare Covered: \$0 copay. During an inpatient acute stay if medically necessary. Inpatient hospital copay rules apply.

Preventive dental services:

- Oral exam (at least 1 per calendar year): \$0 Copay.
- Cleaning (for up to 2 per calendar year): \$0 Copay.
- Fluoride treatment (for up to 2 per calendar year): \$0 Copay.
- Dental X-rays (at least 1 per calendar year): \$0 Copay.

Comprehensive dental services:

Plan covers up to \$1000 per calendar year for combined in and out-of-network non-Medicare covered comprehensive dental services after you pay a \$20 copay for each service.

Supplemental comprehensive dental services include:

- Restorative services
- Endodontics

SECTION II - SUMMARY OF BENEFITS

Clover Health Choice (PPO) (Plan 026)

	<ul style="list-style-type: none">• Periodontics• Extractions• Prosthodontics, Other Oral/Maxillofacial Surgery, and Other Services <p>Supplemental dental benefits should be obtained from a provider in the DentaQuest network.</p>
Vision Services	<p><u>In-Network:</u></p> <p>Medicare-covered exam to diagnose and treat diseases and conditions of the eye: \$15 Copay. Routine eye exam (1 per calendar year): \$0 Copay. Medicare-covered eyeglasses or contact lenses (1 pair after each cataract surgery): \$0 Copay. Routine eyeglasses (lenses and/or frames) or contacts: \$0 Copay.</p> <p>Plan will pay up to \$100 per calendar year for combined in & out-of-network routine contacts or eyeglasses (lenses and/or frames). Supplemental routine vision benefits should be obtained from a provider in the EyeQuest network.</p> <p><u>Out-of-Network:</u></p> <p>Medicare-covered exam to diagnose and treat diseases and conditions of the eye: \$15 Routine eye exam (1 per calendar year): \$0 Copay. Medicare-covered eyeglasses or contact lenses (1 pair after each cataract surgery): \$0 Routine eyeglasses (lenses and/or frames) or contacts: \$0 Copay.</p> <p>Plan will pay up to \$100 per calendar year for combined in & out-of-network routine contacts or eyeglasses (lenses and/or frames). Supplemental routine vision benefits should be obtained from a provider in the EyeQuest network. Members are responsible for any amount above EyeQuest's contracted rates for covered services obtained from providers outside the EyeQuest network.</p>
Mental Health Services	<p><u>In-Network:</u></p> <p>Outpatient group therapy visit: \$15 Copay. Individual therapy visit: \$15 Copay.</p> <p><u>Out-of-Network:</u></p> <p>Outpatient group therapy visit: \$15 Copay. Individual therapy visit: \$15 Copay.</p>

SECTION II - SUMMARY OF BENEFITS

Clover Health Choice (PPO) (Plan 026)

Skilled Nursing Facility (SNF)	<u>In-Network:</u> Days 1-20: \$0 Copay per day. Days 21-100: \$178 Copay per day. <u>Out-of-Network:</u> Days 1-20: \$0 Copay per day. Days 21-100: \$178 Copay per day. Our plan covers up to 100 days each benefit period. No prior hospitalization stay is required.
Physical Therapy	<u>In-Network:</u> Physical therapy and speech and language therapy visit: \$15 Copay. Occupational therapy visit: \$15 Copay. <u>Out-of-Network:</u> Physical therapy and speech and language therapy visit: \$15 Copay. Occupational therapy visit: \$15 Copay.
Ambulance	<u>In-Network:</u> Ground Ambulance: \$220 Copay. Air Ambulance: \$220 Copay. <u>Out-of-Network:</u> Ground Ambulance: \$220 Copay. Air Ambulance: \$220 Copay.
Transportation	\$0 copay for up to 10 one-way non-emergent trips within the plan service area to any health-related location. Each one-way trip must not exceed 50 miles.
Medicare Part B Drugs	<u>In-Network:</u> For Part B drugs such as chemotherapy drugs: 20% Coinsurance. Other Part B drugs: 20% Coinsurance. <u>Out-of-Network:</u> For Part B drugs such as chemotherapy drugs: 20% Coinsurance. Other Part B drugs: 20% Coinsurance.

SECTION II - SUMMARY OF BENEFITS

Clover Health Choice (PPO) (Plan 026)

Ambulatory Surgery Center	<u>In-Network:</u> \$275 copay <u>Out-of-Network:</u> \$275 copay
Foot Care (<i>podiatry services</i>)	<u>In-Network:</u> Medicare-covered foot care: \$15 Copay. Routine foot care: Not covered <u>Out-of-Network:</u> Medicare-covered foot care: \$15 Copay. Routine foot care: Not covered
Durable Medical Equipment	<u>In-Network:</u> 20% Coinsurance. <u>Out-of-Network:</u> 20% Coinsurance.
Prosthetic Devices (<i>braces, artificial limbs, etc.</i>)	<u>In-Network:</u> Prosthetic devices: 20% Coinsurance. Related medical supplies: 20% Coinsurance. <u>Out-of-Network:</u> Prosthetic devices: 20% Coinsurance. Related medical supplies: 20% Coinsurance.
Diabetes Supplies and Services	<u>In-Network:</u> Diabetes monitoring supplies: \$0 Copay. Diabetes self-management training: \$0 Copay. Therapeutic shoes or inserts: \$0 Copay. <u>Out-of-Network:</u> Diabetes monitoring supplies: \$0 Copay.

SECTION II - SUMMARY OF BENEFITS

Clover Health Choice (PPO) (Plan 026)

	Diabetes self-management training: \$0 Copay. Therapeutic shoes or inserts: \$0 Copay.
Wellness Program	\$0 copay for a gym membership through SilverSneakers®.
Over-the-Counter	You pay a \$0 copay for select OTC products through our mail order service, up to a \$100 allowance. Orders are limited to one (1) every three months and benefits are available at the beginning of each quarter of the calendar year (January, April, July, and October). Any unused amount will not be carried over.

PRESCRIPTION DRUG BENEFITS

Deductible Stage	Because there is no deductible for the plan, this payment stage does not apply to you.																																						
Initial Coverage	<p>You pay the following until your total yearly drug costs reach \$4,020. Total yearly drug costs are the drug costs paid by both you and our Part D plan.</p> <p>Standard Retail Cost-Sharing</p> <table border="1"> <thead> <tr> <th>Tier</th> <th>30 day supply</th> <th>60 day supply</th> <th>100 day supply</th> </tr> </thead> <tbody> <tr> <td>Tier 1 (Preferred Generic)</td> <td>\$5 copay</td> <td>\$10 copay</td> <td>\$15 copay</td> </tr> <tr> <td>Tier 2 (Generic)</td> <td>\$15 copay</td> <td>\$30 copay</td> <td>\$45 copay</td> </tr> <tr> <td>Tier 3 (Preferred Brand)</td> <td>\$47 copay</td> <td>\$94 copay</td> <td>\$141 copay</td> </tr> <tr> <td>Tier 4 (Non-Preferred Drug)</td> <td>\$100 copay</td> <td>\$200 copay</td> <td>\$300 copay</td> </tr> <tr> <td>Tier 5 (Specialty Tier)</td> <td>33% coinsurance</td> <td>33% coinsurance</td> <td>33% coinsurance</td> </tr> </tbody> </table> <p>Preferred Retail Cost-Sharing</p> <table border="1"> <thead> <tr> <th>Tier</th> <th>30 day supply</th> <th>60 day supply</th> <th>100 day supply</th> </tr> </thead> <tbody> <tr> <td>Tier 1 (Preferred Generic)</td> <td>\$0 copay</td> <td>\$0 copay</td> <td>\$0 copay</td> </tr> <tr> <td>Tier 2 (Generic)</td> <td>\$10 copay</td> <td>\$20 copay</td> <td>\$30 copay</td> </tr> </tbody> </table>			Tier	30 day supply	60 day supply	100 day supply	Tier 1 (Preferred Generic)	\$5 copay	\$10 copay	\$15 copay	Tier 2 (Generic)	\$15 copay	\$30 copay	\$45 copay	Tier 3 (Preferred Brand)	\$47 copay	\$94 copay	\$141 copay	Tier 4 (Non-Preferred Drug)	\$100 copay	\$200 copay	\$300 copay	Tier 5 (Specialty Tier)	33% coinsurance	33% coinsurance	33% coinsurance	Tier	30 day supply	60 day supply	100 day supply	Tier 1 (Preferred Generic)	\$0 copay	\$0 copay	\$0 copay	Tier 2 (Generic)	\$10 copay	\$20 copay	\$30 copay
Tier	30 day supply	60 day supply	100 day supply																																				
Tier 1 (Preferred Generic)	\$5 copay	\$10 copay	\$15 copay																																				
Tier 2 (Generic)	\$15 copay	\$30 copay	\$45 copay																																				
Tier 3 (Preferred Brand)	\$47 copay	\$94 copay	\$141 copay																																				
Tier 4 (Non-Preferred Drug)	\$100 copay	\$200 copay	\$300 copay																																				
Tier 5 (Specialty Tier)	33% coinsurance	33% coinsurance	33% coinsurance																																				
Tier	30 day supply	60 day supply	100 day supply																																				
Tier 1 (Preferred Generic)	\$0 copay	\$0 copay	\$0 copay																																				
Tier 2 (Generic)	\$10 copay	\$20 copay	\$30 copay																																				

SECTION II - SUMMARY OF BENEFITS

Clover Health Choice (PPO) (Plan 026)

Tier 3 (Preferred Brand)	\$37 copay	\$74 copay	\$111 copay
Tier 4 (Non-Preferred Drug)	\$90 copay	\$180 copay	\$270 copay
Tier 5 (Specialty Tier)	33% coinsurance	33% coinsurance	33% coinsurance

Mail Order

Tier	100 day supply
Tier 1 (Preferred Generic)	\$0 copay
Tier 2 (Generic)	\$20 copay
Tier 3 (Preferred Brand)	\$74 copay
Tier 4 (Non-Preferred Drug)	\$180 copay
Tier 5 (Specialty Tier)	33% coinsurance

Your cost-sharing may be different if you use a Long Term Care pharmacy, home infusion, or an out-of-network pharmacy.

Please call us or see the plan's "**Evidence of Coverage**" on our website (www.cloverhealth.com) for complete information about your costs for covered drugs.

Coverage Gap

The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,020.

After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total \$6,350, which is the end of the coverage gap.

Catastrophic Amount

After your yearly out-of-pocket drug costs reach \$6,350, you pay the greater of:

- \$3.60 copay for generic (including brand drugs treated as generic) and a \$8.95 copayment for all other drugs, or
- 5% of the cost.

DISCLAIMERS

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-888-657-1207 (TTY: 711).

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-888-466-5044 (TTY: 711).

Clover Health Choice (PPO) is a Local PPO plan with a Medicare contract. Enrollment in **Clover Health Choice (PPO)** depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Clover Health members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number or see your "Evidence of Coverage" for more information, including the cost-sharing that applies to out-of-network services.

Health coverage is offered by Clover Insurance Company.