Clover

New Jersey Clover Health Choice Value PPO Plan 007

Your Annual Notice of Change:
All the Details of Your
2019 New Jersey Clover Health Choice Value PPO

Clover

Clover Health Choice Value (PPO) offered by Clover Health

Annual Notice of Changes for 2019

You are currently enrolled as a member of Clover Health NJ Premier Orange (PPO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Section 2 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2019 Drug List and look in Section 2.6 for information about changes to our drug coverage.

OMB Approval 0938-1051 (Pending OMB Approval)

- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices, visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 2.3 for information about our *Provider Directory*.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

If you want to **keep** Clover Health NJ Premier Orange (PPO), you don't need to do anything. You will stay in Clover Health NJ Premier Orange (PPO).

- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2018**

- If you **don't join another plan by December 7, 2018**, you will stay in Clover Health NJ Premier Orange (PPO).

- If you **join another plan by December 7, 2018**, your new coverage will start on January 1, 2019.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-888-657-1207 for additional information. (TTY users should call 711.) Hours are 8 am–8 pm, local time, 7 days a week. From April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
- This document may be made available in large print. Please contact Member Services for more information.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Clover Health Choice Value (PPO)

- Clover Health is a Preferred Provider Organization (PPO) with a Medicare contract. Enrollment in Clover Health depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Clover Health. When it says "plan" or "our plan," it means Clover Health Choice Value (PPO).

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Clover Health Choice Value (PPO) in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the *Evidence of Coverage*, available electronically, to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$33.70	$37.20
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	From network providers: $6,700 From network and out-of-network providers combined: $6,700	From network providers: $6,700 From network and out-of-network providers combined: $6,700
Doctor office visits	Cost sharing is the same for in-network and out-of-network providers. Primary care visits: $0 copay per visit Specialist visits: $5 copay per visit	Cost sharing is the same for in-network and out-of-network providers. Primary care visits: $0 copay per visit Specialist visits: $5 copay per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	Cost sharing is the same for in-network and out-of-network providers. $170 copay per day for days 1-6 and $0 copay per day for days 7-365 for each Medicare-covered hospital stay.	Cost sharing is the same for in-network and out-of-network providers. $170 copay per day for days 1-6 and $0 copay per day for days 7-365 for each Medicare-covered hospital stay.

Cost	2018 (this year)	2019 (next year)
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: $405 (applies to Tier 2, 3, 4, and 5) Copayment/Coinsurance during the Initial Coverage Stage for Standard/Preferred: • Drug Tier 1: $10 copay/$0 copay • Drug Tier 2: 25% coinsurance/22% coinsurance • Drug Tier 3: 25% coinsurance/22% coinsurance • Drug Tier 4: 25% coinsurance for both Standard and Preferred • Drug Tier 5: 25% coinsurance for both Standard and Preferred	Deductible: $415 (applies to Tier 2, 3, 4, and 5) Copayment/Coinsurance during the Initial Coverage Stage for Standard/Preferred: • Drug Tier 1: $10 copay/$0 copay • Drug Tier 2: 25% coinsurance/22% coinsurance • Drug Tier 3: 25% coinsurance/22% coinsurance • Drug Tier 4: 25% coinsurance for both Standard and Preferred • Drug Tier 5: 25% coinsurance for both Standard and Preferred

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SECTION 1 We Are Changing the Plan's Name

On January 1, 2019, our plan name will change from Clover Health NJ Premier Orange (PPO) to Clover Health Choice Value (PPO).

You will be receiving a new membership card for 2019 which will be mailed to your household. The ID card will state your new plan name — Clover Health Choice Value (PPO). Keep your membership card handy when you call to make an appointment or go to a medical facility for care.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$33.70	$37.20

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving "Extra Help" with your prescription drug costs.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. These limits are called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2018 (this year)	2019 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700	$6,700 Once you have paid $6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$6,700	There is no change to the combined maximum out-of-pocket amount for 2019. Once you have paid $6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 2.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider Directory* is located on our website at www.cloverhealth.com/en/members/find-provider. You may also call Member Services for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2019 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.

- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider, or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 2.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated *Pharmacy Directory* is located on our website at www.cloverhealth.com/en/members/find-provider. You may also call Member Services for updated provider information or to ask us to mail you a *Pharmacy Directory*. **Please review the 2019 *Pharmacy Directory* to see which pharmacies are in our network**.

Section 2.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2019 Evidence of Coverage.*

Cost	2018 (this year)	2019 (next year)
Cardiac rehabilitation services	You pay a $10 copay for each Medicare-covered cardiac and intensive cardiac rehabilitation service in & out-of-network.	You pay a $5 copay for each Medicare-covered cardiac and intensive cardiac rehabilitation service in & out-of-network.
Chiropractic services	You pay a $10 copay for each Medicare-covered visit in & out-of-network.	You pay a $5 copay for each Medicare-covered visit in & out-of-network.
Dental services You should see a DentaQuest provider to use this benefit.	**Preventive Dental Services:** Plan covers up to $20 for 1 X-ray every year. Plan covers up to $140 for Preventive Dental out-of-network.	**Preventive Dental Services:** Plan covers up to $40 for 1 X-ray every year. Plan covers up to $160 every year for all Preventive Dental services out-of-network.
Emergency care	You pay a $75 copay for each Medicare-covered emergency room visit.	You pay a $90 copay for each Medicare-covered emergency room visit.

Cost	2018 (this year)	2019 (next year)
Inpatient mental health care	You pay a $130 copay per day for days 1-6 for each stay. $0 copay per day for days 7-365 for each stay.	You pay a $170 copay per day for days 1-6 for each stay. $0 copay per day for days 7-90 for each stay. Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.
Medicare Part B prescription drugs	Medicare Part B prescription drugs were not subject to step therapy.	Before beginning drug therapy for a medical condition for some specified drugs, we'll check to see if the drugs are considered first-line drugs for safety and cost-effectiveness, before progressing to other drugs that may have more side effects or risks or that are more costly.
Outpatient diagnostic tests and therapeutic services and supplies	Diagnostic Mammogram copay will not be waived if there is a Screening Mammogram on the same day. In & out-of-network, you pay a $30 copay for each Medicare-covered therapeutic radiology service in an office setting and/or outpatient facility.	Diagnostic Mammogram copay will be waived if there is a Screening Mammogram on the same day. In & out-of-network, you pay a $60 copay for each Medicare-covered therapeutic radiology service in an office setting and/or outpatient facility.

Cost	2018 (this year)	2019 (next year)
Outpatient diagnostic tests and therapeutic services and supplies *continued*	You pay a $10 copay for each in & out-of-network Medicare-covered lab service. You pay a $10 copay for each in & out-of-network allergy testing visit and treatment. You pay a $30 copay for each in & out-of-network Medicare-covered diagnostic bone mass service.	You pay a $0 copay for each in & out-of-network Medicare-covered lab service. You pay a $0 copay for each in & out-of-network allergy testing visit and treatment. You pay a $0 copay for each in & out-of-network Medicare-covered diagnostic bone mass service.
Outpatient rehabilitation services	You pay a $10 copay for each in & out-of-network Medicare-covered physical therapy & speech language therapy visit. You pay a $10 copay for each in & out-of-network Medicare-covered occupational therapy visit.	You pay a $5 copay for each in & out-of-network Medicare-covered physical therapy & speech language therapy visit. You pay a $5 copay for each in & out-of-network Medicare-covered occupational therapy visit.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	If there is a surgical procedure performed during a screening colonoscopy then the Outpatient Surgery cost share will apply.	Surgery copay will be waived if there is a surgical procedure during a screening colonoscopy.

Cost	2018 (this year)	2019 (next year)
Pulmonary rehabilitation services	You pay a $10 copay for each in & out-of-network Medicare-covered pulmonary rehabilitation service.	You pay a $5 copay for each in & out-of-network Medicare-covered pulmonary rehabilitation service.
Skilled Nursing Facility (SNF) care	You pay a $0 copay per day for days 1-20 for each stay. $160 copay per day for days 21-100 for each stay.	You pay a $0 copay per day for days 1-20 for each stay. $172 copay per day for days 21-100 for each stay.
Supervised Exercise Therapy (SET)	Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) is not covered.	You pay a $5 copay for each in & out-of-network Medicare-covered SET session for PAD.
Vision care You should see an EyeQuest provider to use the routine benefits.	Plan covers up to $50 for one routine eye exam in & out-of-network. You pay a $20 copay for one pair of routine contacts or eyeglasses per year in & out-of-network. Plan will pay up to $100 per year for routine eyewear or contacts after you pay a $20 copay.	Plan covers up to $55 for one routine eye exam every year in & out-of-network. You pay a $0 copay for one pair of routine contacts or eyeglasses per year in & out-of-network. Plan will pay up to $100 per year in & out-of-network for routine eyewear or contacts.

Section 2.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)),* or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. For 2019, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days' supply provided in all other cases: 31-day supply of medication rather than the amount provided in 2018 (98-day supply of medication). (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Current formulary exceptions are not covered into next year. To continue receiving these drug exceptions, you can:

- Work with your doctor (or other prescriber) and ask the plan to make an exception to cover the drug. We encourage current members to ask for an exception before next year. To learn what you must do to ask for an exception, see Chapter 9 of your Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints), or call Member Services.
- Work with your doctor (or other prescriber) to find a different drug that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

Starting in 2019, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost sharing tier or add new restrictions. This means if you are taking the brand name drug that is being replaced by the new generic (or the tier or restriction on the brand name drug changes), you will no longer always get notice of the change 60 days before we make it or get a 60-day refill of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

Also, starting in 2019, before we make other changes during the year to our Drug List that require us to provide you with advance notice if you are taking a drug, we will provide you with notice 30, rather than 60, days before we make the change. Or we will give you a 30-day, rather than a 60-day, refill of your brand name drug at a network pharmacy.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about the changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and haven't received this insert by September 30th, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in Section 7.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages: the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages, the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, available electronically.)

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 2, 3, 4, and 5 drugs until you have reached the yearly deductible.	The deductible is $405. During this stage, you pay $10 cost sharing for drugs on Tier 1 Preferred Generic at standard pharmacies, $0 cost sharing for drugs on Tier 1 Preferred Generic at preferred pharmacies, and the full cost of drugs on Tier 2 Generic, Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, and Tier 5 Specialty until you have reached the yearly deductible.	The deductible is $415. During this stage, you pay $10 cost sharing for drugs on Tier 1 Preferred Generic at standard pharmacies, $0 cost sharing for drugs on Tier 1 Preferred Generic at preferred pharmacies, and the full cost of drugs on Tier 2 Generic, Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, and Tier 5 Specialty until you have reached the yearly deductible.

Changes to Your Cost sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2018 (this year)	2019 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy.	Your cost for a one-month supply at a network pharmacy: **Preferred Generics (Tier 1):** *Standard cost sharing:* You pay $10 per prescription. *Preferred cost sharing:* You pay $0 per prescription. **Non-Preferred Generics (Tier 2):** *Standard cost sharing:* You pay 25% of the total cost per prescription. *Preferred cost sharing:* You pay 22% of the total cost per prescription.	Your cost for a one-month supply at a network pharmacy: **Preferred Generics (Tier 1):** *Standard cost sharing:* You pay $10 per prescription. *Preferred cost sharing:* You pay $0 per prescription. **Non-Preferred Generics (Tier 2):** *Standard cost sharing:* You pay 25% of the total cost per prescription. *Preferred cost sharing:* You pay 22% of the total cost per prescription.

Stage	2018 (this year)	2019 (next year)
For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	**Preferred Brand (Tier 3):** *Standard cost sharing:* You pay 25% of the total cost per prescription. *Preferred cost sharing:* You pay 22% of the total cost per prescription.	**Preferred Brand (Tier 3):** *Standard cost sharing:* You pay 25% of the total cost per prescription. *Preferred cost sharing:* You pay 22% of the total cost per prescription.
We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	**Non-Preferred Drug (Tier 4):** *Standard cost sharing:* You pay 25% of the total cost per prescription. *Preferred cost sharing:* You pay 25% of the total cost per prescription. **Specialty (Tier 5):** *Standard cost sharing:* You pay 25% of the total cost. *Preferred cost sharing:* You pay 25% of the total cost. Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage).	**Non-Preferred Drug (Tier 4):** *Standard cost sharing:* You pay 25% of the total cost per prescription. *Preferred cost sharing:* You pay 25% of the total cost per prescription. **Specialty (Tier 5):** *Standard cost sharing:* You pay 25% of the total cost. *Preferred cost sharing:* You pay 25% of the total cost. Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Clover Health Choice Value (PPO)

To stay in our plan, you don't need to do anything. If you don't sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2019.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year, but if you want to change for 2019, follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR*– You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Clover Health offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Clover Health Choice Value (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Clover Health Choice Value (PPO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
    - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2019.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

Note: If you're in a drug management program, you may not be able to change plans.

If you enrolled in a Medicare Advantage plan for January 1, 2019, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage), or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2019. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In New Jersey, the SHIP is called New Jersey SHIP.

New Jersey SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. New Jersey SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call New Jersey SHIP at 1-800-792-8820 (in state only) or 1-877-222-3737 (out of state). You can learn more about New Jersey SHIP by visiting their website (www.state.nj.us/humanservices/doas/services/ship/index.html).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213 between 7am–7pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications).

- **Help from your state's pharmaceutical assistance program.** New Jersey has a program called Pharmaceutical Assistance to the Aged and Disabled (PAAD) for New Jersey and New Jersey Senior Gold Prescription Discount Program that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 5 of this booklet).
- **Prescription Cost sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residency and HIV status, low-income as defined by the State, and uninsured/underinsured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost sharing assistance through the New Jersey AIDS Drug Distribution Program (ADDP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-877-613-4533.

SECTION 7 Questions?

Section 7.1 – Getting Help from Clover Health Choice Value (PPO)

Questions? We're here to help. Please call Member Services at 1-888-657-1207. (TTY only, call 711.) We are available for phone calls 8 am–8 pm, local time, 7 days a week. From April 1 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays. Calls to these numbers are free.

Read your 2019 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2019. For details, look in the 2019 *Evidence of Coverage* for Clover Health Choice Value (PPO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is available electronically.

Visit our Website

You can also visit our website at www.cloverhealth.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (https://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2019*

You can read the *Medicare & You 2019* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights, and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov), or 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.

Clover is here for you.

Questions? 1-888-657-1207 (TTY 711),
8 am–8 pm local time, 7 days/week*

*Between April 1st and September 30th, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

Clover Health is a Preferred Provider Organization (PPO) plan with a Medicare contract. Enrollment in Clover Health depends on contract renewal. This information is not a complete description of benefits. Call 1-888-657-1207 (TTY 711) for more information.

Out-of-network/non-contracted providers are under no obligation to treat Clover members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Clover Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-888-657-1207 (TTY 711).

Clover Health cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: Si usted habla español, tenemos servicios de asistencia lingüística disponibles para usted sin costo alguno. Llame al 1-888-657-1207 (TTY 711).

Clover Health 遵守適用的聯邦民權法律規定,不因種 族、膚色、民族血統、年齡、殘障 或性別而歧視任何人 。
小贴士:如果您说普通话,欢迎 使用免费语言协助服务。请拨 1-888-657-1207 (TTY 711)。

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