Clover Health

New Jersey
2022 Summary of Benefits

Clover Health Choice (PPO) (001)
Available in Hudson County

Clover Health Choice (PPO) (004)
Available in the following counties: Atlantic, Bergen, Essex, Mercer, Monmouth, Morris, Passaic, Somerset, Sussex, and Union

Clover Health Choice Value (PPO) (007)
Available in the following counties: Atlantic, Bergen, Essex, Hudson, Mercer, Monmouth, Morris, Passaic, Somerset, Sussex, and Union

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) (plan 001), Clover Health Choice (PPO) (plan 004)** and **Clover Health Choice Value (PPO) (plan 007)**
- 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 1-888-778-1478 (TTY/TDD: 711).

Things to Know About Clover Health Choice (PPO) (plan 001), Clover Health Choice (PPO) (plan 004), and Clover Health Choice Value (PPO) (plan 007)

Hours of Operation & Contact Information

- From October 1st to March 31st, we're open 8 a.m. – 8 p.m. local time, 7 days a week.
- From April 1st to September 30th, 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 1-888-778-1478, TTY/TDD: 711.
- If you are not a member of this plan, call us at 1-888-466-5044, TTY/TDD: 711.
- Our website: cloverhealth.com

Who can join?

To join **Clover Health Choice (PPO) (plan 001)**, **Clover Health Choice (PPO) (plan 004)**, and **Clover Health Choice Value (PPO) (plan 007)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and must live in our service area.

The service area for **Clover Health Choice (PPO) (plan 001)** includes the following county in New Jersey: Hudson.

The service area for **Clover Health Choice (PPO) (plan 004)** includes the following counties in New Jersey: Atlantic, Bergen, Essex, Mercer, Monmouth, Morris, Passaic, Somerset, Sussex, and Union.

The service area for **Clover Health Choice Value (PPO) (plan 007)** includes the following counties in New Jersey: Atlantic, Bergen, Essex, Hudson, Mercer, Monmouth, Morris, Passaic, Somerset, Sussex, and Union.

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.

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

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, cloverhealth.com/formulary.
- Or, call us and we will send you a copy of the formulary.

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

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary (Drug List) 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, what pharmacy you use, and what benefit stage you have reached. Later in this document we discuss the benefit stages that occur: Deductible Stage, Initial Coverage, Coverage Gap and Catastrophic Coverage.

For 2022, **Clover Health Choice (PPO) (plan 001)** and **Clover Health Choice (PPO) (plan 004)** participate in the Part D Senior Savings Model which offers lower, stable, and predictable out of pocket costs for covered insulin through the different Part D benefit coverage stages. You will pay a maximum of $35 for a 1-month supply, $70 for a 2-month supply, or up to $105 for a 3-month supply of covered insulin during the deductible, initial coverage and coverage gap or "donut hole" stages of your benefit. Catastrophic phase cost shares would still apply. Your cost may be less if you receive Extra Help from Medicare or if you use a preferred pharmacy. To find out which drugs are Select Insulin Drugs, review the 2022 Drug List.

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 001)	Clover Health Choice (PPO) (plan 004)	Clover Health Choice Value (PPO) (plan 007)
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.	You do not pay a separate monthly plan premium for Clover Health Choice (PPO). You must continue to pay your Medicare Part B premium.	$37.10 per month. In addition, you must keep paying your Medicare Part B premium.
Deductible	Medical Deductible: Not Applicable. Prescription Drugs Deductible: $150. During this stage, you pay the full cost of your Tier 3, 4, and 5 drugs. You stay in this stage until you have paid $150 for your Tier 3, 4, and 5 drugs.	Medical Deductible: Not Applicable. Prescription Drugs Deductible: $150. During this stage, you pay the full cost of your Tier 3, 4, and 5 drugs. You stay in this stage until you have paid $150 for your Tier 3, 4, and 5 drugs.	Medical Deductible: Not Applicable. Prescription Drugs Deductible: $480. During this stage, you pay the full cost of your Tier 2, 3, 4, and 5 drugs. You stay in this stage until you have paid $480 for your Tier 2, 3, 4, and 5 drugs.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $7,550 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.	Your yearly limit(s) in this plan: • $7,550 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.	Your yearly limit(s) in this plan: • $7,550 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.

SECTION II - SUMMARY OF BENEFITS			
	Clover Health Choice (PPO) (plan 001)	Clover Health Choice (PPO) (plan 004)	Clover Health Choice Value (PPO) (plan 007)
	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.	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.	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 font in the Benefits Chart below.			
Inpatient Hospital	**In-Network**: **Days 1-4: $390 Copay per day.** **Days 5-365: $0 Copay per day.** **Out-of-Network**: Days 1-4: $390 Copay per day. Days 5-365: $0 Copay per day.	**In-Network**: **Days 1-4: $390 Copay per day.** **Days 5-365: $0 Copay per day.** **Out-of-Network**: Days 1-4: $390 Copay per day. Days 5-365: $0 Copay per day.	**In-Network**: **Days 1-4: $340 Copay per day.** **Days 5-365: $0 Copay per day.** **Out-of-Network**: Days 1-4: $340 Copay per day. Days 5-365: $0 Copay per day.
Outpatient Hospital	**In-Network**: **Outpatient surgery: $325 copay.** **Surgery copay will be waived if there is a surgical procedure during a screening colonoscopy.**	**In-Network**: **Outpatient surgery: $325 copay.** **Surgery copay will be waived if there is a surgical procedure during a screening colonoscopy.**	**In-Network**: **Outpatient surgery: $200 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 001)	Clover Health Choice (PPO) (plan 004)	Clover Health Choice Value (PPO) (plan 007)
	Out-of-Network: Outpatient surgery: $325 copay. Surgery copay will be waived if there is a surgical procedure during a screening colonoscopy.	**Out-of-Network**: Outpatient surgery: $325 copay. Surgery copay will be waived if there is a surgical procedure during a screening colonoscopy.	**Out-of-Network**: Outpatient surgery: $200 copay. Surgery copay will be waived if there is a surgical procedure during a screening colonoscopy.
Doctor's Office Visits	**In-Network**: Primary care physician visit: $0 Copay. Specialist visit: $10 Copay. **Out-of-Network**: Primary care physician visit: $0 Copay. Specialist visit: $10 Copay.	**In-Network**: Primary care physician visit: $0 Copay. Specialist visit: $10 Copay. **Out-of-Network**: Primary care physician visit: $0 Copay. Specialist visit: $10 Copay.	**In-Network**: Primary care physician visit: $0 Copay. Specialist visit: $5 Copay. **Out-of-Network**: Primary care physician visit: $0 Copay. Specialist visit: $5 Copay.
Preventive Care *(e.g., flu vaccine, diabetic screenings)*	**In-and-Out-of-Network**: $0 Copay for all preventive services covered under Original Medicare. Any additional preventive services approved by Medicare during the contract year will be covered.	**In-and-Out-of-Network**: $0 Copay for all preventive services covered under Original Medicare. Any additional preventive services approved by Medicare during the contract year will be covered.	**In-and-Out-of-Network**: $0 Copay for all preventive services covered under Original Medicare. Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	**In-and-Out-of-Network**: $90 Copay per visit. Worldwide Coverage: $90 Copay.	**In-and-Out-of-Network**: $90 Copay per visit. Worldwide Coverage: $90 Copay.	**In-and-Out-of-Network**: $90 Copay per visit. Worldwide Coverage: Not Covered.

SECTION II - SUMMARY OF BENEFITS			
	Clover Health Choice (PPO) (plan 001)	Clover Health Choice (PPO) (plan 004)	Clover Health Choice Value (PPO) (plan 007)
	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.	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.	Copay is waived if you are admitted to the hospital within 24 hours.
Urgently Needed Services	**In-and-Out-of-Network**: $25 Copay per visit. Worldwide Coverage: $40 Copay. 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.	**In-and-Out-of-Network**: $25 Copay per visit. Worldwide Coverage: $40 Copay. 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.	**In-and-Out-of-Network**: $25 Copay per visit. Worldwide Coverage: Not covered. Copay is waived if you are admitted to the hospital within 24 hours.

SECTION II - SUMMARY OF BENEFITS			
	Clover Health Choice (PPO) (plan 001)	Clover Health Choice (PPO) (plan 004)	Clover Health Choice Value (PPO) (plan 007)
Diagnostic Services / Labs / Imaging	**<u>In-Network</u>:** **Diagnostic tests and procedures - Office setting or imaging center: up to a $50 copay** **Diagnostic tests and procedures - Outpatient facility: $175 copay** **Labs services: $10 copay** **Advanced Radiology (such as MRI, PET, CT, Nuclear medicine) - office setting or imaging center: up to a $50 copay** **Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine) - outpatient facility: $175 copay** **X-rays services: $30 copay** **Therapeutic radiology (radiation): $60 copay**	**<u>In-Network</u>:** **Diagnostic tests and procedures - Office setting or imaging center: up to a $50 copay** **Diagnostic tests and procedures - Outpatient facility: $175 copay** **Labs services: $10 copay** **Advanced Radiology (such as MRI, PET, CT, Nuclear medicine) - office setting or imaging center: up to a $50 copay** **Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine) - outpatient facility: $175 copay** **X-rays services: $30 copay** **Therapeutic radiology (radiation): $60 copay**	**<u>In-Network</u>:** **Diagnostic tests and procedures - Office setting or imaging center: up to a $50 copay** **Diagnostic tests and procedures - Outpatient facility: $175 copay** **Labs services: $0 copay** **Advanced Radiology (such as MRI, PET, CT, Nuclear medicine) - office setting or imaging center: up to a $50 copay** **Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine) - outpatient facility: $175 copay** **X-rays services: $30 copay** **Therapeutic radiology (radiation): $60 copay**

SECTION II - SUMMARY OF BENEFITS			
	Clover Health Choice (PPO) (plan 001)	Clover Health Choice (PPO) (plan 004)	Clover Health Choice Value (PPO) (plan 007)
	Out-of-Network: Diagnostic tests and procedures - Office setting or imaging center: up to a $50 copay Diagnostic tests and procedures - Outpatient facility: $175 copay Labs services: $40 copay Advanced Radiology (such as MRI, PET, CT, Nuclear medicine) - office setting or imaging center: up to a $50 copay Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine) - outpatient facility: $175 copay X-rays services: $30 copay Therapeutic radiology (radiation): $60 copay	**Out-of-Network**: Diagnostic tests and procedures - Office setting or imaging center: up to a $50 copay Diagnostic tests and procedures - Outpatient facility: $175 copay Labs services: $40 copay Advanced Radiology (such as MRI, PET, CT, Nuclear medicine) - office setting or imaging center: up to a $50 copay Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine) - outpatient facility: $175 copay X-rays services: $30 copay Therapeutic radiology (radiation): $60 copay	**Out-of-Network**: Diagnostic tests and procedures - Office setting or imaging center: up to a $50 copay Diagnostic tests and procedures - Outpatient facility: $175 copay Labs services: $40 copay Advanced Radiology (such as MRI, PET, CT, Nuclear medicine) - office setting or imaging center: up to a $50 copay Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine) - outpatient facility: $175 copay X-rays services: $30 copay Therapeutic radiology (radiation): $60 copay

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Hearing Services	**In-Network**: Medicare-covered diagnostic hearing exam: $20 copay Routine hearing exam (1 per calendar year): $0 copay Hearing aids (up to 2 aids per calendar year - one per ear per year): all types $699 copay for Advanced aids through a TruHearing provider $999 copay for Premium aids through a TruHearing provider **Out-of-Network**: Medicare-covered diagnostic hearing exam: $20 copay Routine hearing exam (1 per calendar year): $0 copay Hearing aids (up to 2 aids per calendar year - one per ear per year): all types $999 copayment per aid	**In-Network**: Medicare-covered diagnostic hearing exam: $20 copay Routine hearing exam (1 per calendar year): $0 copay Hearing aids (up to 2 aids per calendar year - one per ear per year): all types $699 copay for Advanced aids through a TruHearing provider $999 copay for Premium aids through a TruHearing provider **Out-of-Network**: Medicare-covered diagnostic hearing exam: $20 copay Routine hearing exam (1 per calendar year): $0 copay Hearing aids (up to 2 aids per calendar year - one per ear per year): all types $999 copayment per aid	**In-Network**: Medicare-covered diagnostic hearing exam: $5 copay Routine hearing exam (1 per calendar year): $0 copay Hearing aids (up to 2 aids per calendar year - one per ear per year): all types $699 copay for Advanced aids through a TruHearing provider $999 copay for Premium aids through a TruHearing provider **Out-of-Network**: Medicare-covered diagnostic hearing exam: $5 copay Routine hearing exam (1 per calendar year): $0 copay Hearing aids (up to 2 aids per calendar year - one per ear per year): all types $999 copayment per aid

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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 (1 per calendar year): $0 Copay. • Cleaning (for up to 2 per calendar year): $0 Copay. • Dental X-rays (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	**In-Network**: Medicare Covered: $0 Copay during an inpatient acute stay if medically necessary. Inpatient hospital copay rules apply. Preventive dental services: • Oral exam (1 per calendar year): $0 Copay. • Cleaning (for up to 2 per calendar year): $0 Copay. • Dental X-rays (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	**In-Network**: Medicare Covered: $0 Copay during an inpatient acute stay if medically necessary. Inpatient hospital copay rules apply. Preventive dental services: • Oral exam (1 per calendar year): $0 Copay. • Cleaning (for up to 2 per calendar year): $0 Copay. • Dental X-rays (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

SECTION II - SUMMARY OF BENEFITS			
	Clover Health Choice (PPO) (plan 001)	Clover Health Choice (PPO) (plan 004)	Clover Health Choice Value (PPO) (plan 007)
	Out-of-Network: Medicare Covered: $20 Copay during an inpatient acute stay if medically necessary. Inpatient hospital copay rules apply. Preventive dental services: • Oral exam (1 per calendar year): $0 Copay. • Cleaning (for up to 2 per calendar year): $0 Copay. • Dental X-rays (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: $20 Copay during an inpatient acute stay if medically necessary. Inpatient hospital copay rules apply. Preventive dental services: • Oral exam (1 per calendar year): $0 Copay. • Cleaning (for up to 2 per calendar year): $0 Copay. • Dental X-rays (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: $20 Copay during an inpatient acute stay if medically necessary. Inpatient hospital copay rules apply. Preventive dental services: • Oral exam (1 per calendar year): $0 Copay. • Cleaning (for up to 2 per calendar year): $0 Copay. • Dental X-rays (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

SECTION II - SUMMARY OF BENEFITS			
	Clover Health Choice (PPO) (plan 001)	Clover Health Choice (PPO) (plan 004)	Clover Health Choice Value (PPO) (plan 007)
	Supplemental dental benefits should be obtained from a provider in the DentaQuest network.	Supplemental dental benefits should be obtained from a provider in the DentaQuest network.	Supplemental dental benefits should be obtained from a provider in the DentaQuest network.
Vision Services	**In-Network**: Medicare-covered exam to diagnose and treat diseases and conditions of the eye: $20 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. Plan will pay up to $200 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. **Out-of-Network**: Medicare-covered exam to diagnose and treat diseases and conditions of the eye: $20 Copay.	**In-Network**: Medicare-covered exam to diagnose and treat diseases and conditions of the eye: $20 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. Plan will pay up to $200 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. **Out-of-Network**: Medicare-covered exam to diagnose and treat diseases and conditions of the eye: $20 Copay.	**In-Network**: Medicare-covered exam to diagnose and treat diseases and conditions of the eye: $5 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. Plan will pay up to $200 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. **Out-of-Network**: Medicare-covered exam to diagnose and treat diseases and conditions of the eye: $5 Copay.

SECTION II - SUMMARY OF BENEFITS			
	Clover Health Choice (PPO) (plan 001)	Clover Health Choice (PPO) (plan 004)	Clover Health Choice Value (PPO) (plan 007)
	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. Plan will pay up to $200 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.	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. Plan will pay up to $200 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.	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. Plan will pay up to $200 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.
Mental Health Services	**In-Network:** **Outpatient group therapy visit: $20 Copay.** **Individual therapy visit: $20 Copay.** **Out-of-Network:** Outpatient group therapy visit: $20 Copay. Individual therapy visit: $20 Copay.	**In-Network:** **Outpatient group therapy visit: $20 Copay.** **Individual therapy visit: $20 Copay.** **Out-of-Network:** Outpatient group therapy visit: $20 Copay. Individual therapy visit: $20 Copay.	**In-Network:** **Outpatient group therapy visit: $5 Copay.** **Individual therapy visit: $5 Copay.** **Out-of-Network:** Outpatient group therapy visit: $5 Copay. Individual therapy visit: $5 Copay.

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	Clover Health Choice (PPO) (plan 001)	Clover Health Choice (PPO) (plan 004)	Clover Health Choice Value (PPO) (plan 007)
Skilled Nursing Facility (SNF)	**In-Network:** **Days 1-20: $0 Copay per day.** **Days 21-100: $178 Copay per day.** **Out-of-Network:** Days 1-20: 30% Coinsurance per day. Days 21-100: 30% Coinsurance per day. Our plan covers up to 100 days each benefit period. No prior hospitalization stay is required.	**In-Network:** **Days 1-20: $0 Copay per day.** **Days 21-100: $178 Copay per day.** **Out-of-Network:** Days 1-20: 30% Coinsurance per day. Days 21-100: 30% Coinsurance per day. Our plan covers up to 100 days each benefit period. No prior hospitalization stay is required.	**In-Network:** **Days 1-20: $0 Copay per day.** **Days 21-100: $188 Copay per day.** **Out-of-Network:** Days 1-20: 30% Coinsurance per day. Days 21-100: 30% Coinsurance per day. Our plan covers up to 100 days each benefit period. No prior hospitalization stay is required.
Physical Therapy	**In-Network:** **Physical therapy and speech and language therapy visit: $20 Copay.** **Occupational therapy visit: $20 Copay.** **Out-of-Network:** Physical therapy and speech and language therapy visit: $50 Copay. Occupational therapy visit: $50 Copay.	**In-Network:** **Physical therapy and speech and language therapy visit: $20 Copay.** **Occupational therapy visit: $20 Copay.** **Out-of-Network:** Physical therapy and speech and language therapy visit: $50 Copay. Occupational therapy visit: $50 Copay.	**In-Network:** **Physical therapy and speech and language therapy visit: $5 Copay.** **Occupational therapy visit: $5 Copay.** **Out-of-Network:** Physical therapy and speech and language therapy visit: $50 Copay. Occupational therapy visit: $50 Copay.
Ambulance	**In-Network:** **Ground Ambulance: $250 Copay.** **Air Ambulance: $250 Copay.**	**In-Network:** **Ground Ambulance: $300 Copay.** **Air Ambulance: $300 Copay.**	**In-Network:** **Ground Ambulance: $250 Copay.** **Air Ambulance: $250 Copay.**

SECTION II - SUMMARY OF BENEFITS			
	Clover Health Choice (PPO) (plan 001)	Clover Health Choice (PPO) (plan 004)	Clover Health Choice Value (PPO) (plan 007)
	Out-of-Network: Ground Ambulance: $250 Copay. Air Ambulance: $250 Copay.	**Out-of-Network**: Ground Ambulance: $300 Copay. Air Ambulance: $300 Copay.	**Out-of-Network**: Ground Ambulance: $250 Copay. Air Ambulance: $250 Copay.
Transportation	Not Covered.	Not Covered.	Not Covered.
Medicare Part B Drugs	**In-Network**: **For Part B drugs such as chemotherapy drugs: 20% Coinsurance.** **Other Part B drugs: 20% Coinsurance.** **Out-of-Network:** For Part B drugs such as chemotherapy drugs: 40% Coinsurance. Other Part B drugs: 40% Coinsurance.	**In-Network**: **For Part B drugs such as chemotherapy drugs: 20% Coinsurance.** **Other Part B drugs: 20% Coinsurance.** **Out-of-Network:** For Part B drugs such as chemotherapy drugs: 40% Coinsurance. Other Part B drugs: 40% Coinsurance.	**In-Network**: **For Part B drugs such as chemotherapy drugs: 20% Coinsurance.** **Other Part B drugs: 20% Coinsurance.** **Out-of-Network:** For Part B drugs such as chemotherapy drugs: 40% Coinsurance. Other Part B drugs: 40% Coinsurance.
Ambulatory Surgery Center	**In-Network**: **$200 Copay.** **Out-of-Network:** $200 Copay.	**In-Network**: **$225 Copay.** **Out-of-Network:** $225 Copay.	**In-Network**: **$125 Copay.** **Out-of-Network:** $125 Copay.
Foot Care (podiatry services)	**In-Network**: Medicare-covered foot care: $20 Copay. Routine foot care: Not covered. **Out-of-Network:** Medicare-covered foot care: $20 Copay. Routine foot care: Not covered.	**In-Network**: Medicare-covered foot care: $20 Copay. Routine foot care: Not covered. **Out-of-Network:** Medicare-covered foot care: $20 Copay. Routine foot care: Not covered.	**In-Network**: Medicare-covered foot care: $5 Copay. Routine foot care: Not covered. **Out-of-Network:** Medicare-covered foot care: $5 Copay. Routine foot care: Not covered.

SECTION II - SUMMARY OF BENEFITS			
	Clover Health Choice (PPO) (plan 001)	Clover Health Choice (PPO) (plan 004)	Clover Health Choice Value (PPO) (plan 007)
Durable Medical Equipment	**In-Network**: **20% Coinsurance.** **Out-of-Network:** 20% Coinsurance.	**In-Network**: **20% Coinsurance.** **Out-of-Network:** 20% Coinsurance.	**In-Network**: **20% Coinsurance.** **Out-of-Network:** 20% Coinsurance.
Prosthetic Devices *(braces, artificial limbs, etc.)*	**In-Network**: **Prosthetic devices: 20% Coinsurance.** **Related medical supplies: 20% Coinsurance.** **Out-of-Network:** Prosthetic devices: 20% Coinsurance. Related medical supplies: 20% Coinsurance.	**In-Network**: **Prosthetic devices: 20% Coinsurance.** **Related medical supplies: 20% Coinsurance.** **Out-of-Network:** Prosthetic devices: 20% Coinsurance. Related medical supplies: 20% Coinsurance.	**In-Network**: **Prosthetic devices: 20% Coinsurance.** **Related medical supplies: 20% Coinsurance.** **Out-of-Network:** Prosthetic devices: 20% Coinsurance. Related medical supplies: 20% Coinsurance.
Diabetes Supplies and Services	**In-Network**: Diabetes monitoring supplies from a pharmacy: $0 Copay. Preferred products = One-Touch Test Strips & monitors and Accu-Chek Test Strips & monitors. Diabetes monitoring supplies from a DME supplier: 20% Coinsurance. Diabetes self-management training: $0 Copay. Therapeutic shoes or inserts: $0 Copay.	**In-Network**: Diabetes monitoring supplies from a pharmacy: $0 Copay. Preferred products = One-Touch Test Strips & monitors and Accu-Chek Test Strips & monitors. Diabetes monitoring supplies from a DME supplier: 20% Coinsurance. Diabetes self-management training: $0 Copay. Therapeutic shoes or inserts: $0 Copay.	**In-Network**: Diabetes monitoring supplies from a pharmacy: $0 Copay. Preferred products = One-Touch Test Strips & monitors and Accu-Chek Test Strips & monitors. Diabetes monitoring supplies from a DME supplier: 20% Coinsurance. Diabetes self-management training: $0 Copay. Therapeutic shoes or inserts: $0 Copay.

SECTION II - SUMMARY OF BENEFITS			
	Clover Health Choice (PPO) (plan 001)	Clover Health Choice (PPO) (plan 004)	Clover Health Choice Value (PPO) (plan 007)
	Out-of-Network: Diabetes monitoring supplies from a pharmacy: $0 Copay. Diabetes monitoring supplies from a DME supplier: 20% Coinsurance. Diabetes self-management training: $0 Copay. Therapeutic shoes or inserts: $0 Copay.	**Out-of-Network**: Diabetes monitoring supplies from a pharmacy: $0 Copay. Diabetes monitoring supplies from a DME supplier: 20% Coinsurance. Diabetes self-management training: $0 Copay. Therapeutic shoes or inserts: $0 Copay.	**Out-of-Network**: Diabetes monitoring supplies from a pharmacy: $0 Copay. Diabetes monitoring supplies from a DME supplier: 20% Coinsurance. Diabetes self-management training: $0 Copay. Therapeutic shoes or inserts: $0 Copay.
Wellness Program	$0 copay for a gym membership through SilverSneakers®.	$0 copay for a gym membership through SilverSneakers®.	$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 $75 allowance. Members are eligible for the allowance every quarter to use towards the purchase of select over-the counter (OTC) products. Any unused amount will not be carried over to the next quarter. Allowances start over at the beginning of each quarter.	You pay a $0 copay for select OTC products through our mail order service, up to a $75 allowance. Members are eligible for the allowance every quarter to use towards the purchase of select over-the counter (OTC) products. Any unused amount will not be carried over to the next quarter. Allowances start over at the beginning of each quarter.	You pay a $0 copay for select OTC products through our mail order service, up to a $125 allowance. Members are eligible for the allowance every quarter to use towards the purchase of select over-the counter (OTC) products. Any unused amount will not be carried over to the next quarter. Allowances start over at the beginning of each quarter.
Dialysis Services	**In-and-Out-of-Network:** 20% Coinsurance.	**In-and-Out-of-Network:** 20% Coinsurance.	**In-and-Out-of-Network:** 20% Coinsurance.

SECTION II - SUMMARY OF BENEFITS			
	Clover Health Choice (PPO) (plan 001)	Clover Health Choice (PPO) (plan 004)	Clover Health Choice Value (PPO) (plan 007)
Lab services and tests for COVID-19	**In-and-Out-of-Network:** $0 Copay.	**In-and-Out-of-Network:** $0 Copay.	**In-and-Out-of-Network:** $0 Copay.
Grocery Plus	If you qualify, you can use the $75 quarterly Over-the-Counter (OTC) allowance to purchase approved OTC and/or grocery items. To get the grocery benefit, you must have one or more qualifying health condition(s). Please visit cloverhealth.com/grocery-plus or call Member Services for details.	If you qualify, you can use the $75 quarterly Over-the-Counter (OTC) allowance to purchase approved OTC and/or grocery items. To get the grocery benefit, you must have one or more qualifying health condition(s). Please visit cloverhealth.com/grocery-plus or call Member Services for details.	If you qualify, you can use the $125 quarterly Over-the-Counter (OTC) allowance to purchase approved OTC and/or grocery items. To get the grocery benefit, you must have one or more qualifying health condition(s). Please visit cloverhealth.com/grocery-plus or call Member Services for details.
PRESCRIPTION DRUG BENEFITS			
Deductible Stage	During this stage, you pay the full cost of your Tier 3, 4, and 5 drugs. You stay in this stage until you have paid $150 for your Tier 3, 4, and 5 drugs.	During this stage, you pay the full cost of your Tier 3, 4, and 5 drugs. You stay in this stage until you have paid $150 for your Tier 3, 4, and 5 drugs.	During this stage, you pay the full cost of your Tier 2, 3, 4, and 5 drugs. You stay in this stage until you have paid $480 for your Tier 2, 3, 4, and 5 drugs.
Initial Coverage	You pay the following until your total yearly drug costs reach $4,430. Total yearly drug costs are the drug costs paid by both you and our Part D plan.	You pay the following until your total yearly drug costs reach $4,430. Total yearly drug costs are the drug costs paid by both you and our Part D plan.	You pay the following until your total yearly drug costs reach $4,430. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

SECTION II - SUMMARY OF BENEFITS

Clover Health Choice (PPO) (plan 001)

Preferred Retail Cost-Sharing

Tier	30-day supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$10 copay
Tier 3 (Preferred Brand)	$37 copay
Select Insulin Drugs	$25 copay
Tier 4 (Non-Preferred Drug)	$90 copay
Tier 5 (Specialty Tier)	30% coin-surance

Tier	60-day supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$20 copay
Tier 3 (Preferred Brand)	$74 copay
Select Insulin Drugs	$50 copay
Tier 4 (Non-Preferred Drug)	$180 copay
Tier 5 (Specialty Tier)	30% coin-surance

Clover Health Choice (PPO) (plan 004)

Preferred Retail Cost-Sharing

Tier	30-day supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$10 copay
Tier 3 (Preferred Brand)	$37 copay
Select Insulin Drugs	$25 copay
Tier 4 (Non-Preferred Drug)	$90 copay
Tier 5 (Specialty Tier)	30% coin-surance

Tier	60-day supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$20 copay
Tier 3 (Preferred Brand)	$74 copay
Select Insulin Drugs	$50 copay
Tier 4 (Non-Preferred Drug)	$180 copay
Tier 5 (Specialty Tier)	30% coin-surance

Clover Health Choice Value (PPO) (plan 007)

Preferred Retail Cost-Sharing

Tier	30-day supply
Tier 1 (Preferred Generic)	$2 copay
Tier 2 (Generic)	22% coin-surance
Tier 3 (Preferred Brand)	22% coin-surance
Tier 4 (Non-Preferred Drug)	25% coin-surance
Tier 5 (Specialty Tier)	25% coin-surance

Tier	60-day supply
Tier 1 (Preferred Generic)	$4 copay
Tier 2 (Generic)	22% coin-surance
Tier 3 (Preferred Brand)	22% coin-surance
Tier 4 (Non-Preferred Drug)	25% coin-surance
Tier 5 (Specialty Tier)	25% coin-surance

SECTION II - SUMMARY OF BENEFITS

Clover Health Choice (PPO) (plan 001)

Tier	100-day supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$30 copay
Tier 3 (Preferred Brand)	$111 copay
Select Insulin Drugs	$75 copay
Tier 4 (Non-Preferred Drug)	$270 copay
Tier 5 (Specialty Tier)	30% coin-surance

Standard Retail Cost-Sharing

Tier	30-day supply
Tier 1 (Preferred Generic)	$10 copay
Tier 2 (Generic)	$15 copay
Tier 3 (Preferred Brand)	$47 copay
Select Insulin Drugs	$35 copay
Tier 4 (Non-Preferred Drug)	$100 copay
Tier 5 (Specialty Tier)	30% coin-surance

Clover Health Choice (PPO) (plan 004)

Tier	100-day supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$30 copay
Tier 3 (Preferred Brand)	$111 copay
Select Insulin Drugs	$75 copay
Tier 4 (Non-Preferred Drug)	$270 copay
Tier 5 (Specialty Tier)	30% coin-surance

Standard Retail Cost-Sharing

Tier	30-day supply
Tier 1 (Preferred Generic)	$10 copay
Tier 2 (Generic)	$15 copay
Tier 3 (Preferred Brand)	$47 copay
Select Insulin Drugs	$35 copay
Tier 4 (Non-Preferred Drug)	$100 copay
Tier 5 (Specialty Tier)	30% coin-surance

Clover Health Choice Value (PPO) (plan 007)

Tier	100-day supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	22% coin-surance
Tier 3 (Preferred Brand)	22% coin-surance
Tier 4 (Non-Preferred Drug)	25% coin-surance
Tier 5 (Specialty Tier)	25% coin-surance

Standard Retail Cost-Sharing

Tier	30-day supply
Tier 1 (Preferred Generic)	$12 copay
Tier 2 (Generic)	25% coin-surance
Tier 3 (Preferred Brand)	25% coin-surance
Tier 4 (Non-Preferred Drug)	25% coin-surance
Tier 5 (Specialty Tier)	25% coin-surance

SECTION II - SUMMARY OF BENEFITS

	Clover Health Choice (PPO) (plan 001)	Clover Health Choice (PPO) (plan 004)	Clover Health Choice Value (PPO) (plan 007)
	Tier / **60-day supply** Tier 1 (Preferred Generic) — $20 copay Tier 2 (Generic) — $30 copay Tier 3 (Preferred Brand) — $94 copay Select Insulin Drugs — $70 copay Tier 4 (Non-Preferred Drug) — $200 copay Tier 5 (Specialty Tier) — 30% coinsurance	**Tier** / **60-day supply** Tier 1 (Preferred Generic) — $20 copay Tier 2 (Generic) — $30 copay Tier 3 (Preferred Brand) — $94 copay Select Insulin Drugs — $70 copay Tier 4 (Non-Preferred Drug) — $200 copay Tier 5 (Specialty Tier) — 30% coinsurance	**Tier** / **60-day supply** Tier 1 (Preferred Generic) — $24 copay Tier 2 (Generic) — 25% coinsurance Tier 3 (Preferred Brand) — 25% coinsurance Tier 4 (Non-Preferred Drug) — 25% coinsurance Tier 5 (Specialty Tier) — 25% coinsurance
	Tier / **100-day supply** Tier 1 (Preferred Generic) — $5 copay Tier 2 (Generic) — $45 copay Tier 3 (Preferred Brand) — $141 copay Select Insulin Drugs — $105 copay Tier 4 (Non-Preferred Drug) — $300 copay Tier 5 (Specialty Tier) — 30% coinsurance	**Tier** / **100-day supply** Tier 1 (Preferred Generic) — $5 copay Tier 2 (Generic) — $45 copay Tier 3 (Preferred Brand) — $141 copay Select Insulin Drugs — $105 copay Tier 4 (Non-Preferred Drug) — $300 copay Tier 5 (Specialty Tier) — 30% coinsurance	**Tier** / **100-day supply** Tier 1 (Preferred Generic) — $5 copay Tier 2 (Generic) — 25% coinsurance Tier 3 (Preferred Brand) — 25% coinsurance Tier 4 (Non-Preferred Drug) — 25% coinsurance Tier 5 (Specialty Tier) — 25% coinsurance

SECTION II - SUMMARY OF BENEFITS

<table>
<tr><th></th><th>Clover Health Choice (PPO) (plan 001)</th><th>Clover Health Choice (PPO) (plan 004)</th><th>Clover Health Choice Value (PPO) (plan 007)</th></tr>
<tr><td></td>
<td>Mail Order
<table>
<tr><th>Tier</th><th>100-day supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$0 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$110 copay</td></tr>
<tr><td>Select Insulin Drugs</td><td>$75 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$270 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>30% coinsurance</td></tr>
</table></td>
<td>Mail Order
<table>
<tr><th>Tier</th><th>100-day supply</th></tr>
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<table>
<tr><th>Tier</th><th>100-day supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$0 copay</td></tr>
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<tr><td>Tier 4 (Non-Preferred Drug)</td><td>25% coinsurance</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>25% coinsurance</td></tr>
</table></td></tr>
<tr><td></td>
<td>Your cost-sharing may be different if you use a Long Term Care pharmacy, home infusion pharmacy, or an out-of-network pharmacy.
Please call us or see the plan’s “Evidence of Coverage” on our website (cloverhealth.com/eoc) for complete information about your costs for covered drugs.</td>
<td>Your cost-sharing may be different if you use a Long Term Care pharmacy, home infusion pharmacy, or an out-of-network pharmacy.
Please call us or see the plan’s “Evidence of Coverage” on our website (cloverhealth.com/eoc) for complete information about your costs for covered drugs.</td>
<td>Your cost-sharing may be different if you use a Long Term Care pharmacy, home infusion pharmacy, or an out-of-network pharmacy.
Please call us or see the plan’s “Evidence of Coverage” on our website (cloverhealth.com/eoc) for complete information about your costs for covered drugs.</td></tr>
<tr><td>Coverage Gap</td>
<td>The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430.</td>
<td>The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430.</td>
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</table>

SECTION II - SUMMARY OF BENEFITS			
	Clover Health Choice (PPO) (plan 001)	Clover Health Choice (PPO) (plan 004)	Clover Health Choice Value (PPO) (plan 007)
	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 $7,050, which is the end of the coverage gap.	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 $7,050, which is the end of the coverage gap.	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 $7,050, which is the end of the coverage gap.
Catastrophic Amount	After your yearly out-of-pocket drug costs reach $7,050, you pay the greater of: • $3.95 copay for generic (including brand drugs treated as generic) and a $9.85 copayment for all other drugs, or • 5% of the cost.	After your yearly out-of-pocket drug costs reach $7,050, you pay the greater of: • $3.95 copay for generic (including brand drugs treated as generic) and a $9.85 copayment for all other drugs, or • 5% of the cost.	After your yearly out-of-pocket drug costs reach $7,050, you pay the greater of: • $3.95 copay for generic (including brand drugs treated as generic) and a $9.85 copayment for all other drugs, or • 5% of the cost.
Select Insulin Drugs	For 2022, this plan participates in the Part D Senior Savings Model which offers lower, stable, and predictable out of pocket costs for covered insulin through the different Part D benefit coverage stages. You will pay a maximum of $35 for a 1-month supply, $70 for a 2-month supply, or up to $105 for a 3-month supply of covered insulin during the deductible, initial coverage and coverage gap or "donut hole" stages of your benefit. Catastrophic phase cost shares would still apply. Your cost may be less if you receive Extra Help from Medicare or if you use a preferred pharmacy. To find out which drugs are Select Insulin Drugs, review the 2022 Drug List.	For 2022, this plan participates in the Part D Senior Savings Model which offers lower, stable, and predictable out of pocket costs for covered insulin through the different Part D benefit coverage stages. You will pay a maximum of $35 for a 1-month supply, $70 for a 2-month supply, or up to $105 for a 3-month supply of covered insulin during the deductible, initial coverage and coverage gap or "donut hole" stages of your benefit. Catastrophic phase cost shares would still apply. Your cost may be less if you receive Extra Help from Medicare or if you use a preferred pharmacy. To find out which drugs are Select Insulin Drugs, review the 2022 Drug List.	This plan does not participate in the Part D Senior Savings Model in 2022.

DISCLAIMERS

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-888-778-1478 (TTY/TDD: 711).

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-888-778-1478 (TTY/TDD: 711).

Clover Health has Local PPO plans with a Medicare contract. Enrollment in **Clover Health Choice (PPO) (plan 001), Clover Health Choice (PPO) (plan 004),** and **Clover Health Choice Value (PPO) (plan 007)** 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 Health Insurance Company.

We're here to help.

1-888-778-1478 (TTY/TDD 711)

8 am–8 pm local time, 7 days/week*

Visit us at cloverhealth.com/enroll

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*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 and a Health Maintenance Organization (HMO) plan with a Medicare contract. Enrollment in Clover Health depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat Clover Health 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.

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