Clover

Texas Green (Plan 025)—2018 Medical Benefits

Effective Date: 1/1/2018 | Version 1.0

Medical Benefit Description	In-Network	Out-of-Network
Part D Deductible For **Part D Copay** information, see page 26.	**$150**/year for Part D prescription drugs Tiers 1 and 2 are not subject to the deductible.	**$150**/year for Part D prescription drugs Tiers 1 and 2 are not subject to the deductible.
Out-of-Pocket Max	**$6,700**/year Does not include prescription drugs or supplemental benefits.	**$6,700**/year Does not include prescription drugs or supplemental benefits.
Counties	Bexar	Bexar
INPATIENT CARE		
Inpatient Hospital Care Includes Substance Abuse and Rehabilitation Services *May require prior authorization	**$200** copay/day Days 1–6 **$0** copay/day Days 7–365 Copay applies per stay.	**35%** of the cost for each hospital stay
Inpatient Mental Health Care *May require prior authorization	**$200** copay/day Days 1–6 **$0** copay/day Days 7–365 Copay applies per stay.	**35%** of the cost for each hospital stay

Coinsurance will always be taken on applicable services in addition to the copay.

Medical Benefit Description	In-Network	Out-of-Network
INPATIENT CARE *(continued)*		
Skilled Nursing Facility In a Medicare-certified skilled nursing facility *May require prior authorization	**$0** copay/day Days 1–20 **$160** copay/day Days 21–100 No prior hospital stay is required. Member is covered for 100 days/benefit period.	**45%** of the cost for each skilled nursing facility stay No prior hospital stay is required. Member is covered for 100 days/benefit period.
Inpatient Ancillary Services	**$0**	**$0**
Hospice	Member must receive care from a Medicare-certified Hospice. When enrolled in a hospice program, hospice services and Part A and Part B services related to the terminal prognosis are paid for by Original Medicare, not Clover Health. Clover Health will pay for a consultative visit before selecting a hospice.	Member must receive care from a Medicare-certified Hospice. When enrolled in a hospice program, hospice services and Part A and Part B services related to the terminal prognosis are paid for by Original Medicare, not Clover Health. Clover Health will pay for a consultative visit before selecting a hospice.

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Medical Benefit Description	In-Network	Out-of-Network
OUTPATIENT CARE		
Physician Services Including doctor office visits for illness/injury	**$5** for each primary care office visit and Outpatient Medical Procedures by a PCP **$30** for each specialist office visit and other Outpatient Medical Procedures by a Specialist **Clover recognized PCPs:** Family Practice, General Practice, Internal Medicine, OB-GYN, Geriatric Medicine. Copay is taken on facility claim, not the professional claim, if applicable.	**45%** of the cost for each primary care office visit and Outpatient Medical Procedures by a PCP **45%** of the cost for each specialist office visit and other Outpatient Medical Procedures by a Specialist **Clover recognized PCPs:** Family Practice, General Practice, Internal Medicine, OB-GYN, Geriatric Medicine. Coinsurance is taken on the both facility claim and the professional claim, if applicable.
Home Health Care Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc. *May require prior authorization	**$0** for all Medicare covered home health visits and home therapy sessions	**45%** of the cost for all Medicare covered home health visits and home therapy sessions
Chiropractic Services	**$20** for each Medicare covered chiropractic service (manual manipulation of the spine to correct subluxation). Limit to 30 visits/year. No coverage for routine chiropractic services.	**45%** of the cost for each Medicare covered chiropractic service (manual manipulation of the spine to correct subluxation). Limit to 30 visits/year. No coverage for routine chiropractic services.

Medical Benefit Description	In-Network	Out-of-Network
OUTPATIENT CARE *(continued)*		
Podiatry Services	**$30** for each Medicare covered podiatry visit and podiatry surgery No coverage for routine podiatry services.	**45%** of the cost for each Medicare covered podiatry visit and podiatry surgery No coverage for routine podiatry services.
Outpatient Rehabilitation Services You pay per visit. *May require prior authorization	**$30** for each Medicare covered Physical Therapy session Limit to $2,010 per year combined with Speech Therapy. **$30** for each Medicare covered Occupational Therapy session Limit to $2,010 per year. **$30** for each Medicare covered Speech/Language Therapy session Limit to $2,010 per year combined with Physical Therapy. **$30** for each Medicare covered Cardiac Rehab session, Intensive Cardiac Rehab service, Pulmonary Rehab session, and for other Medicare covered therapy sessions **Cardiac Rehab:** Limit to 36 sessions per year. **Intensive Cardiac Rehab:** Limit to 72 sessions per year. **Pulmonary Rehab:** Limit to 36 sessions per year.	**45%** of the cost for each Medicare covered Physical Therapy session Limit to $2,010 per year combined with Speech Therapy. **45%** of the cost for each Medicare covered Occupational Therapy session Limit to $2,010 per year. **45%** of the cost for each Medicare covered Speech/Language Therapy session Limit to $2,010 per year combined with Physical Therapy. **45%** of the cost for each Medicare covered Cardiac Rehab session, Intensive Cardiac Rehab service, Pulmonary Rehab session, and for other Medicare covered therapy sessions **Cardiac Rehab:** Limit to 36 sessions per year. **Intensive Cardiac Rehab:** Limit to 72 sessions per year. **Pulmonary Rehab:** Limit to 36 sessions per year.

Medical Benefit Description	In-Network	Out-of-Network
OUTPATIENT CARE *(continued)*		
Outpatient Mental Health Including Partial Hospitalization *May require prior authorization	**$30** for each Medicare covered individual therapy visit, group therapy visit, and mental health services **$30** for each Medicare covered individual therapy visit with a psychiatrist, group therapy visit with a psychiatrist, and mental health services with a psychiatrist **$30** per day for Medicare covered partial hospitalization program services	**45%** of the cost for each Medicare covered individual therapy visit, group therapy visit, and mental health services **45%** of the cost for each Medicare covered individual therapy visit with a psychiatrist, group therapy visit with a psychiatrist, and mental health services with a psychiatrist **45%** of the cost per day for Medicare covered partial hospitalization program services
Outpatient Observation	**$0** if admitted to inpatient from observation; inpatient R&B copay will apply **$100** if admitted to observation through ER **$210** if observation leads to surgery **$100** if discharged home from observation	**$0** if admitted to inpatient from observation; inpatient R&B copay will apply **45%** of the cost if admitted to observation through ER **45%** of the cost if observation leads to surgery **45%** of the cost if discharged home from observation
Outpatient Substance Abuse Care *May require prior authorization	**$30** for each Medicare covered substance abuse service (with or without a psychiatrist)	**45%** of the cost for each Medicare covered substance abuse service (with or without a psychiatrist)

Medical Benefit Description	In-Network	Out-of-Network
OUTPATIENT CARE *(continued)*		
Ambulatory Surgery *May require prior authorization	**$150** for each Medicare covered visit to an ambulatory surgical center	**45%** of the cost for each Medicare covered visit to an ambulatory surgical center
Outpatient Surgery & Supplies *May require prior authorization	**$210** for each Medicare covered visit to an outpatient hospital facility **$5** for each Medicare covered visit in an office setting by a PCP, except for diagnostic colonoscopy (see Diagnostic Colonoscopy category) **$30** for each Medicare covered visit in an office setting by a Specialist, except for diagnostic colonoscopy (see Diagnostic Colonoscopy category)	**45%** of the cost for each Medicare covered visit to an outpatient hospital facility **45%** of the cost for each Medicare covered visit in an office setting by a PCP **45%** of the cost for each Medicare covered visit in an office setting by a Specialist
Anesthesia	**$0** for each Medicare covered anesthesia service	**45%** of the cost for each Medicare covered anesthesia service
Ambulance Services Medically necessary ambulance services *May require prior authorization	**$300**/one-way trip for Medicare covered ambulance transports Copay will not be waived if admitted to the hospital.	**$300**/one-way trip for Medicare covered ambulance transports Copay will not be waived if admitted to the hospital.

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

Medical Benefit Description	In-Network	Out-of-Network
OUTPATIENT CARE *(continued)*		
Diabetes Self-Monitoring Training and Supplies Includes coverage for glucose monitors, test strips, lancets, screening tests, and self management training	**$0** for Medicare covered Diabetes self-management training **Initial Year:** up to 10 hours of training within a continuous 12-month period **Subsequent Year:** up to 2 hours of training each year after the initial year **45%** of the cost for Medicare-covered Diabetes monitors or strips with HCPCS codes A4253, E0607, E2100, E2101 from a DME supplier **$0** for all other Medicare-covered Diabetes supplies from a DME supplier **$0** of the cost for Johnson & Johnson One-Touch Test Strips & monitors and Roche Diagnostics Accu-Chek Test Strips & monitors when obtained from an in-network pharmacy **$0** for Medicare-covered therapeutic shoes or inserts Limit to 1 pair of diabetic shoes per year. Limit to 3 pairs of diabetic shoe inserts per year.	**45%** of the cost for Medicare covered Diabetes self-management training **Initial Year:** up to 10 hours of training within a continuous 12-month period **Subsequent Year:** up to 2 hours of training each year after the initial year **45%** of the cost for each Medicare covered Diabetes monitors or strips from a DME supplier **45%** of the cost for all other Medicare-covered Diabetes supplies from a DME supplier **45%** of the cost for Medicare covered therapeutic shoes or inserts Limit to 1 pair of diabetic shoes per year. Limit to 3 pairs of diabetic shoe inserts per year.

Medical Benefit Description	In-Network	Out-of-Network
OUTPATIENT CARE *(continued)*		
If a member receives multiple diagnostic tests and therapeutic services (e.g. labs, X-rays, and radiation) at the same location on the same day, only the maximum cost share applies.		
Clinical/Diagnostic Labs *May require prior authorization	**Up to $10** for Medicare-covered clinical/diagnostic lab or pathology service **$0** for venipuncture, transportation, and set up of lab equipment	**45%** of the cost for Medicare-covered clinical/diagnostic lab or pathology service **$0** for venipuncture, transportation, and set up of lab equipment
Radiation Therapy *May require prior authorization	**Up to $30** for each radiation therapy service	**45%** of the cost for each radiation therapy service
Radiology/X-Rays	**Up to $30** for each General Radiology/X-ray service **$0** for the transportation & set up of X-Ray equipment	**45%** of the cost for each General Radiology/X-ray service **$0** for the transportation & set up of X-Ray equipment
Advanced Radiology Including MRA, MRI, Nuclear Med, PET scans, & CAT Scans *May require prior authorization	**Up to $100** for Advanced Radiology services Limit to 1 per lifetime for PET Beta Amyloid Dementia and Neurodegenerative Disease.	**45%** of the cost for Advanced Radiology services Limit to 1 per lifetime for PET Beta Amyloid Dementia and Neurodegenerative Disease.
Diagnostic Tests—Allergy	**Up to $10** for Allergy services (includes testing and treatment) from a PCP or specialist	**45%** of the cost for Allergy services (includes testing and treatment) from a PCP or specialist

Medical Benefit Description	In-Network	Out-of-Network
OUTPATIENT CARE *(continued)*		
If a member receives multiple diagnostic tests and therapeutic services (e.g. labs, X-rays, and radiation) at the same location on the same day, only the maximum cost share applies.		
Diagnostic Tests—Cardiology *May require prior authorization	**Up to $75** for each Cardiology service in an outpatient setting **Up to $30** for each Cardiology service in an office setting	**45%** of the cost for each Cardiology service
Diagnostic Tests—Echo *May require prior authorization	**Up to $75** for each Echography service in an outpatient setting **Up to $30** for each Echography service in an office setting	**45%** of the cost for each Echography service
Diagnostic Tests—EEG *May require prior authorization	**Up to $75** for each EEG service in an outpatient setting **Up to $30** for each EEG service in an office setting	**45%** of the cost for each EEG service
Diagnostic Tests—EKG	**$0** for each EKG service	**45%** of the cost for each EKG service
Diagnostic Tests—Gastroenterology *May require prior authorization	**Up to $75** for each Gastroenterology service in an outpatient setting **Up to $30** for each Gastroenterology service in an office setting	**45%** of the cost for each Gastroenterology service

Medical Benefit Description	In-Network	Out-of-Network
OUTPATIENT CARE *(continued)*		
If a member receives multiple diagnostic tests and therapeutic services (e.g. labs, X-rays, and radiation) at the same location on the same day, only the maximum cost share applies.		
Diagnostic Tests—Other Diagnostic Services *May require prior authorization	**Up to $75** for each Diagnostic service in an outpatient setting **Up to $30** for each Diagnostic service in an office setting	**45%** of the cost for each Diagnostic service
Diagnostic Tests—Pulmonary *May require prior authorization	**Up to $75** for each Pulmonary service in an outpatient setting **Up to $30** for each Pulmonary service in an office setting	**45%** of the cost for each Pulmonary service
Diagnostic Tests—Sleep Study *May require prior authorization	**Up to $75** for each Sleep Study service in an outpatient setting **Up to $30** for each Sleep Study service in an office setting	**45%** of the cost for each Sleep Study service
Diagnostic Tests—Ultrasound	**Up to $75** for each Ultrasound service in an outpatient setting **Up to $30** for each Ultrasound service in an office setting	**45%** of the cost for each Ultrasound service
Diagnostic Tests—Vascular *May require prior authorization	**Up to $75** for each Vascular service in an outpatient setting **Up to $30** for each Vascular service in an office setting	**15%** of the cost for each Vascular service

Medical Benefit Description	In-Network	Out-of-Network
OUTPATIENT CARE *(continued)*		
If a member receives multiple diagnostic tests and therapeutic services (e.g. labs, X-rays, and radiation) at the same location on the same day, only the maximum cost share applies.		
Diagnostic Colonoscopy *May require prior authorization	**Up to $290** for each Diagnostic Colonoscopy in an outpatient setting **Up to $150** for each Diagnostic Colonoscopy in an office or ASC setting	**45%** of the cost for each Diagnostic Colonoscopy
Diagnostic Bone Mass Measurement	**Up to $75** for each Medicare covered Diagnostic Bone Mass Measurement in an outpatient setting **Up to $30** for each Medicare covered Diagnostic Bone Mass Measurement in an office setting	**45%** of the cost for each Medicare Covered Diagnostic Bone Mass Measurement
Diagnostic Mammogram	**Up to $75** for each Medicare covered Diagnostic Mammgoram in an outpatient setting **Up to $30** for each Medicare covered Diagnostic Mammogram in an office setting	**45%** of the cost for each Medicare Covered Diagnostic Mammogram
Chemotherapy *May require prior authorization	**20%** of the cost for each chemotherapy service, chemotherapy drug, and Oncology Service	**45%** of the cost for each chemotherapy service, chemotherapy drug, and Oncology Service

Medical Benefit Description	In-Network	Out-of-Network
OUTPATIENT CARE *(continued)*		
Surgical Supplies, Splints, and Casts *May require prior authorization	**20%** of the cost for surgical supplies, dressings, splints & casts when billed on a 1500 by DME supplier or when billed on a hospital claim	**20%** of the cost for surgical supplies, dressings, splints & casts when billed on a 1500 by DME supplier or when billed on a hospital claim
Blood	Coverage for blood, storage, and administration begins w/ the 1st pint of blood. **$0** per unit of blood for Medicare covered benefits	Coverage for blood, storage, and administration begins w/ the 1st pint of blood. **45%** of the cost per unit of blood for Medicare covered benefits
Outpatient Part B Drugs & Injectables Covered under Medicare Part B *May require prior authorization	**20%** of the cost for outpatient Part B Drugs & Injectables, Infusion Therapy, Nebulizer Drugs, and Imaging Agents Limit of 1 per month for B-12 injection. Limit of 1 per lifetime for PET Beta Amyloid Dementia and Neurodegenerative Disease. Limit of 3 per lifetime for Autogous Cellar Immuntherapy.	**45%** of the cost for outpatient Part B Drugs & Injectables, Infusion Therapy, Nebulizer Drugs, and Imaging Agents Limit of 1 per month for B-12 injection. Limit of 1 per lifetime for PET Beta Amyloid Dementia and Neurodegenerative Disease. Limit of 3 per lifetime for Autogous Cellar Immuntherapy.
Renal Dialysis	**20%** of the cost for Medicare Covered renal dialysis **$0** for Medicare Covered kidney disease education services **20%** of the cost for outpatient dialysis services Limit to 6 sessions (individual or group) per lifetime for Kidney Disease Education.	**45%** of the cost for Medicare Covered renal dialysis **45%** of the cost for Medicare Covered kidney disease education services **45%** of the cost for outpatient dialysis services Limit to 6 sessions (individual or group) per lifetime for Kidney Disease Education.

Medical Benefit Description	In-Network	Out-of-Network
PREVENTIVE SERVICES		
Abdominal Aortic Aneurysm (AAA) Screening	**$0** for each Abdominal Aortic Aneurysm (AAA) screening Limit to 1 per lifetime.	**45%** of the cost for each Abdominal Aortic Aneurysm (AAA) screening Limit to 1 per lifetime.
Alcohol Misuse Screening and Counseling	**$0** for each alcohol misuse screening/counseling service Limit to 1 per year for misuse screening, 15 min. Limit to 4 times per year for brief face-to-face counseling, 15 min.	**45%** of the cost for each alcohol misuse screening/counseling service Limit to 1 per year for misuse screening, 15 min. Limit to 4 times per year for brief face-to-face counseling, 15 min.
Annual Wellness Visit (AWV) This is not the IPPE	**$0** for the annual wellness visit Limit to 1 per year.	**45%** of the cost for the annual wellness visit Limit to 1 per year.
Bone Mass Measurement Screening	**$0** for each Medicare covered Preventive Bone Mass Measurement Limit to 1 every 24 months.	**45%** of the cost for each Medicare covered Preventive Bone Mass Measurement Limit to 1 every 24 months.
Cardiovascular Screening Blood Tests	**$0** for each Medicare covered cardiovascular disease screening test Limit to 1 every 5 years.	**45%** of the cost for each Medicare covered cardiovascular disease screening test Limit to 1 every 5 years.

Medical Benefit Description	In-Network	Out-of-Network
PREVENTIVE SERVICES *(continued)*		
Colorectal Cancer Screening Exams For people with Medicare age 50 and older & others at high risk regardless of age. Outpatient Surgery copay will apply if there is a surgical procedure during a screening colonoscopy.	**$0** for each Fecal Occult blood test Limit 1 per year. **$0** for each Flexible Sigmoidoscopy Limit to 1 every 4 years. (If a screening colonoscopy has been performed, Clover may cover a screening flexible sigmoidoscopy only after 10 years.) **$0** for each Screening Colonoscopy Limit to 1 every 24 months at high risk. Limit to 1 every 10 years not at high risk. (For any risk, if a screening flexible sigmoidoscopy has been performed Clover may cover a screening colonoscopy only after 4 years.) **$0** for each Barium Enema Limit to 1 every 24 months at high risk. Limit to 1 every 4 years not at high risk. **$0** for each Colorectal Cancer Screening with Cologuard Limit to 1 per 3 years.	**45%** of the cost for each Fecal Occult blood test Limit 1 per year. **45%** of the cost for each Flexible Sigmoidoscopy Limit to 1 every 4 years. (If a screening colonoscopy has been performed, Clover may cover a screening flexible sigmoidoscopy only after 10 years.) **45%** of the cost for each Screening Colonoscopy Limit to 1 every 24 months at high risk. Limit to 1 every 10 years not at high risk. (For any risk, if a screening flexible sigmoidoscopy has been performed Clover may cover a screening colonoscopy only after 4 years.) **45%** of the cost for each Barium Enema Limit to 1 every 24 months at high risk. Limit to 1 every 4 years not at high risk. **45%** of the cost for each Colorectal Cancer Screening with Cologuard Limit to 1 per 3 years.

Medical Benefit Description	In-Network	Out-of-Network
PREVENTIVE SERVICES *(continued)*		
Diabetes Screening Test	**$0** for each Diabetes screening test Limit to 2 per year for beneficiaries diagnosed with pre-diabetes. Limit to 1 screening per year if previously tested but not diagnosed with pre-diabetes, or if never tested.	**45%** of the cost for each Diabetes screening test Limit to 2 per year for beneficiaries diagnosed with pre-diabetes. Limit to 1 screening per year if previously tested but not diagnosed with pre-diabetes, or if never tested.
Glaucoma Screening	**$0** for each Medicare covered Glaucoma screening test Limit to 1 per year.	**45%** of the cost for each Medicare covered Glaucoma screening test Limit to 1 per year.
Health & Wellness Education Programs	**$0** for a SilverSneakers® membership To find a fitness center that participates in the SilverSneakers® network, please visit **https://www.silversneakers.com/locations**	No coverage for non-participating SilverSneakers® fitness centers
Smoking Cessation	**$0** for each Medicare covered smoking and tobacco use cessation Limit to 2 cessation attempts per year. Each attempt may include a maximum of 4 intermediate or intensive sessions, with the total annual benefit covering up to 8 sessions per year.	**45%** of the cost for each Medicare covered smoking and tobacco use cessation Limit to 2 cessation attempts per year. Each attempt may include a maximum of 4 intermediate or intensive sessions, with the total annual benefit covering up to 8 sessions per year.

Medical Benefit Description	In-Network	Out-of-Network
PREVENTIVE SERVICES *(continued)*		
HIV Screening	**$0** for each voluntary HIV screening Limit to 1 per year. Limit to 3 per year when pregnant: (1) when the diagnosis of pregnancy is known (2) during the third trimester, and/or (3) at labor if ordered by the physician	**45%** of the cost for each voluntary HIV screening Limit to 1 per year. Limit to 3 per year when pregnant: (1) when the diagnosis of pregnancy is known (2) during the third trimester, and/or (3) at labor if ordered by the physician
Immunizations Flu vaccine, Hepatitis B vaccine & Pneumonia vaccine	**$0** for the administration of each vaccine, for each Medicare covered Flu vaccine, Pneumonia vaccine, Hepatitis B vaccine, and other covered immunizations Limit to 2 Flu vaccines per year. Limit to 2 Pneumonia vaccines per lifetime.	**45%** of the cost for the administration of each vaccine, for each Medicare covered Flu vaccine, Pneumonia vaccine, Hepatitis B vaccine, and other covered immunizations Limit to 2 Flu vaccines per year. Limit to 2 Pneumonia vaccines per lifetime.
Initial Preventive Physical Exam Also known as the "Welcome to Medicare Preventive Visit"	**$0** for the physical exam Limit to 1 per lifetime. Must be furnished no later than 12 months after the effective date of the first Medicare Part B Coverage.	**45%** of the cost for the physical exam Limit to 1 per lifetime. Must be furnished no later than 12 months after the effective date of the first Medicare Part B Coverage.

Medical Benefit Description	In-Network	Out-of-Network
PREVENTIVE SERVICES *(continued)*		
Intensive Behavioral Therapy	**$0** for each IBT for cardiovascular disease Limit of 1 per year. **$0** for each IBT for obesity service Limit of 22 per year.	**45%** of the cost for each IBT for cardiovascular disease Limit of 1 per year. **45%** of the cost for each IBT for obesity service Limit of 22 per year.
Lung Cancer Screening Counseling and Annual Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)	**$0** for each Lung Cancer Screening Counseling **$0** for each Lung Cancer Screening w/LDCT Limit of 1 per 12 months.	**45%** of the cost for each Lung Cancer Screening Counseling **45%** of the cost for each Lung Cancer Screening w/LDCT Limit of 1 per 12 months.
Screening Mammograms	**$0** for each Medicare covered baseline mammogram Limit to 1 baseline mammogram for women between the ages of 35–39. **$0** for each Medicare covered screening mammogram Limit to 1 screening mammogram every 12 months for women over 40.	**45%** of the cost for each Medicare covered baseline mammogram Limit to 1 baseline mammogram for women between the ages of 35–39. **45%** of the cost for each Medicare covered screening mammogram Limit to 1 screening mammogram every 12 months for women over 40.

Medical Benefit Description	In-Network	Out-of-Network
PREVENTIVE SERVICES *(continued)*		
Medical Nutrition Therapy (MNT) For people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by a doctor	**$0** for each Medicare covered Medical Nutrition Therapy visit/service Limit to 3 hours of one-on-one counseling in the 1st year, and 2 hours for each subsequent year.	**45%** of the cost for each Medicare covered Medical Nutrition Therapy visit/service Limit to 3 hours of one-on-one counseling in the 1st year, and 2 hours for each subsequent year.
Pap Smears and Pelvic Exams	**$0** for each Medicare covered pap smear and for each Medicare covered pelvic & breast exam Limit to 1 screening pap and 1 pelvic exam every 12 months for women at high risk or at childbearing age w/ abnormal pap in the past 3 years. Limit to 1 screening pap and 1 pelvic exam every 24 months for all other women.	**45%** of the cost for each Medicare covered pap smear and for each Medicare covered pelvic & breast exam Limit to 1 screening pap and 1 pelvic exam every 12 months for women at high risk or at childbearing age w/ abnormal pap in the past 3 years. Limit to 1 screening pap and 1 pelvic exam every 24 months for all other women.
Prostate Cancer Screening Exams For men with Medicare age 50 and older	**$0** for each Medicare covered digital rectal exam (DRE) and for each Medicare covered prostate specific antigen test (PSA) Limit to 1 DRE every 12 months. Limit to 1 PSA every 12 months.	**45%** of the cost for each Medicare covered digital rectal exam (DRE) and for each Medicare covered prostate specific antigen test (PSA) Limit to 1 DRE every 12 months. Limit to 1 PSA every 12 months.
Routine Physical Exams This is not the IPPE.	No coverage for routine physical exams.	No coverage for routine physical exams.
Screening for Cervical Cancer with Human Papillomavirus (HPV) Tests	**$0** for each cervical cancer screening with human papillomavirus (HPV) tests Limit to 1 every 5 years.	**45%** of the cost for each cervical cancer screening with human papillomavirus (HPV) tests Limit to 1 every 5 years.

Medical Benefit Description	In-Network	Out-of-Network
PREVENTIVE SERVICES *(continued)*		
Screening for Depression	**$0** for each depression screening service Limit to 1 per year, 15 min.	**45%** of the cost for each depression screening service Limit to 1 per year, 15 min.
Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs	**$0** for each STI/HIBC service **Coverage for chlamydia, gonorrhea, syphilis, and Hepatitis B only:** Limit to 1 screening per year for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant. Limit to 1 screening per year for syphilis in men at increased risk. Limit up to 2 screenings per pregnancy for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening. Limit to 1 screening per pregnancy for syphilis in pregnant women; up to 2 additional screenings in the third trimester and at delivery if at continued increased risk for STIs. Limit to 1 screening per pregnancy for hepatitis B in pregnant women; 1 additional screening at delivery if at continued increased risk for STIs. Limit up to 2 face-to-face, 20–30 minute, HIBC sessions per year.	**$45** for each STI/HIBC service **Coverage for chlamydia, gonorrhea, syphilis, and Hepatitis B only:** Limit to 1 screening per year for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant. Limit to 1 screening per year for syphilis in men at increased risk. Limit up to 2 screenings per pregnancy for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening. Limit to 1 screening per pregnancy for syphilis in pregnant women; up to 2 additional screenings in the third trimester and at delivery if at continued increased risk for STIs. Limit to 1 screening per pregnancy for hepatitis B in pregnant women; 1 additional screening at delivery if at continued increased risk for STIs. Limit up to 2 face-to-face, 20–30 minute, HIBC sessions per year.

Medical Benefit Description	In-Network	Out-of-Network
PREVENTIVE SERVICES *(continued)*		
Hepatitis C Virus Screening	**$0** for each Hepatitis C screening Limit to 1 per lifetime or 1 per year depending on diagnosis code.	**45%** of the cost for each Hepatitis C screening Limit to 1 per lifetime or 1 per year depending on diagnosis code.
Medicare Diabetes Prevention Program (MDPP) Effective 4/1/2018	**$0** for each MDPP session Limit to 1 year of core and core maintenance sessions followed by up to 1 year of ongoing maintenance sessions. Member must meet weight loss and attendance goals.	**45%** of the cost for each MDPP session Limit to 1 year of core and core maintenance sessions followed by up to 1 year of ongoing maintenance sessions. Member must meet weight loss and attendance goals.

Medical Benefit Description	In-Network	Out-of-Network
ADDITIONAL SERVICES		
Dental Services	**$0** for each Medicare covered Dental service **$0** for each Non-Medicare covered Preventive Dental service when received from a DentaQuest provider. Limit 2 preventive exams per year. Limit 2 preventive clearnings per year. Limit 1 preventive x-ray per year. Contracted rates apply for services from non-participating DentaQuest providers. For more information, call Clover Provider Services at 1-877-853-8019 or DentaQuest Provider Services at 888-308-9345. To find a provider visit **www.dentaquest.com/find-a-provider/cloverdental** No coverage for Comprehensive Dental services.	**35%** of the cost for each Medicare-covered Dental service **$0** for each Non-Medicare covered Preventive Dental service when received from a DentaQuest provider. Limit 2 preventive exams per year. Limit 2 preventive clearnings per year. Limit 1 preventive x-ray per year. Contracted rates apply for services from non-participating DentaQuest providers. For more information, call Clover Provider Services at 1-877-853-8019 or DentaQuest Provider Services at 888-308-9345. To find a provider visit **www.dentaquest.com/find-a-provider/cloverdental** No coverage for Comprehensive Dental services.

Medical Benefit Description	In-Network	Out-of-Network
ADDITIONAL SERVICES *(continued)*		
Hearing Services	**$30** for each Medicare covered diagnostic hearing exam and each Medicare covered audiology service **$0** for a Non-Medicare covered routine hearing exam from a TruHearing provider Limit to 1 routine hearing exam per year. **$699** for each Flyte Advanced hearing aid from a TruHearing provider **$999** for each Flyte Premium hearing aid from a TruHearing provider Limit to 2 hearing aids per year; 1 per ear per year. 3 hearing aid fittings/evaluation visits are included as part of hearing aid purchase.	**45%** of the cost for each Medicare covered diagnostic hearing exam and each Medicare covered audiology service No coverage for routine hearing exam, hearing aid, and hearing aid fitting/evaluation.

Medical Benefit Description	In-Network	Out-of-Network
ADDITIONAL SERVICES *(continued)*		
Vision Services	**$30** for Medicare covered diagnostic exams to diagnose and treat diseases and conditions of the eye. Refraction is covered and will take applicable copay if performed as a stand-alone service. **$0** for Medicare covered post-cataract surgery eyewear. Limit to 1 pair of glasses or contacts after each cataract surgery. **$0** for a Non-Medicare covered routine eye exam (includes refraction) when seen by an EyeQuest provider. Limit to 1 routine eye exam/year. **$150** allowance for supplemental eyewear (frames, lenses and/or contact lenses) per year.	**45%** of the cost for Medicare covered diagnostic exams to diagnose and treat diseases and conditions of the eye. Refraction is covered and will take applicable coinsurance if performed as a stand-alone service. **20%** of the cost for Medicare covered post-cataract surgery eyewear. Limit to 1 pair of glasses or contacts after each cataract surgery. **$0** for a Non-Medicare covered routine eye exam (includes refraction) when seen by an EyeQuest provider. Limit to 1 routine eye exam/year. **$150** allowance for supplemental eyewear (frames, lenses and/or contact lenses) per year.

Medical Benefit Description	In-Network	Out-of-Network
NON-COVERED BENEFITS		
Miscellaneous Non Plan Covered Services	• Acupuncture • Athletic Training • Cosmetic Dermatology • Routine Transportation without preauthorization • Self Administered Drugs (SADS) • Miscellaneous non-covered Items • Bundled Services • Demonstration Projects • Billing Errors • Non Medically Necessary Services • Report Only Codes	• Acupuncture • Athletic Training • Cosmetic Dermatology • Routine Transportation without preauthorization • Self Administered Drugs (SADS) • Miscellaneous non-covered Items • Bundled Services • Demonstration Projects • Billing Errors • Non Medically Necessary Services • Report Only Codes

Part D Copays

Texas Green (Plan 025)

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

Rx deductible $150. Deductible appplies to tiers 3, 4, & 5. Tiers 1 & 2 are exempt from deductible. **Service Area:** Bexar

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