# Clover Health

# Tennessee
## 2022 Summary of Benefits

**Clover Health Choice (PPO) (033)**
Available in the following counties: Davidson, Rutherford, and Williamson

**Clover Health Choice Value (PPO) (034)**
Available in the following counties: Davidson, Rutherford, and Williamson

## 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 033)** and **Clover Health Choice Value (PPO) (plan 034)**
- 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 033)** and **Clover Health Choice Value (PPO) (plan 034)**

**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 033)** and **Clover Health Choice Value (PPO) (plan 034)**, 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 033)** includes the following counties in Tennessee: Davidson, Rutherford, and Williamson.

The service area for **Clover Health Choice Value (PPO) (plan 034)** includes the following counties in Tennessee: Davidson, Rutherford, and Williamson.

### What do we cover?

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

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

## SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

- 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, both of these plans 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 033) | Clover Health Choice Value (PPO) (plan 034) |
| **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) (plan 033). You must continue to pay your Medicare Part B premium. | $32.70 per month. In addition, you must keep paying your Medicare Part B premium. |
| **Deductible** | Medical Deductible: Not Applicable.<br><br>Prescription Drugs Deductible: Not Applicable. | Medical Deductible: Not Applicable.<br><br>Prescription Drugs Deductible: Not Applicable. |
| **Maximum Out-of-Pocket Responsibility** | Your yearly limit(s) in this plan:<br>• $7,550 for services you receive from in and out-of-network providers combined.<br><br>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.<br><br>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. | Your yearly limit(s) in this plan:<br>• $7,550 for services you receive from in and out-of-network providers combined.<br><br>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.<br><br>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. |

| SECTION II - SUMMARY OF BENEFITS | | |
|---|---|---|
| | Clover Health Choice (PPO) (plan 033) | Clover Health Choice Value (PPO) (plan 034) |
| **COVERED MEDICAL AND HOSPITAL BENEFITS**<br>Covered services that need approval in advance are marked in bold font in the Benefits Chart below. | | |
| **Inpatient Hospital** | **In-Network**:<br>**Days 1-5: $275 Copay per day.**<br>**Days 6-365: $0 Copay per day.**<br>**Out-of-Network**:<br>Days 1-5: $320 Copay per day.<br>Days 6-365: $0 Copay per day. | **In-Network**:<br>**Days 1-5: $275 Copay per day.**<br>**Days 6-365: $0 Copay per day.**<br>**Out-of-Network**:<br>Days 1-5: $320 Copay per day.<br>Days 6-365: $0 Copay per day. |
| **Outpatient Hospital** | **In-Network**:<br>**Outpatient surgery: $295 copay.**<br><br>**Surgery copay will be waived if there is a surgical procedure during a screening colonoscopy.**<br><br>**Out-of-Network**:<br>Outpatient surgery: $375 copay.<br><br>Surgery copay will be waived if there is a surgical procedure during a screening colonoscopy. | **In-Network**:<br>**Outpatient surgery: $275 copay.**<br><br>**Surgery copay will be waived if there is a surgical procedure during a screening colonoscopy.**<br><br>**Out-of-Network**:<br>Outpatient surgery: $350 copay.<br><br>Surgery copay will be waived if there is a surgical procedure during a screening colonoscopy. |
| Doctor's Office Visits | **In-Network**:<br>Primary care physician visit: $0 Copay.<br>Specialist visit: $20 Copay.<br>**Out-of-Network**:<br>Primary care physician visit: $5 Copay.<br>Specialist visit: $30 Copay. | **In-Network**:<br>Primary care physician visit: $0 Copay.<br>Specialist visit: $0 Copay.<br>**Out-of-Network**:<br>Primary care physician visit: $5 Copay.<br>Specialist visit: $20 Copay. |
| Preventive Care<br>*(e.g., flu vaccine, diabetic screenings)* | **In-Network**:<br>$0 Copay for all preventive services covered under Original Medicare. | **In-Network**:<br>$0 Copay for all preventive services covered under Original Medicare. |

| SECTION II - SUMMARY OF BENEFITS | | |
|---|---|---|
| | Clover Health Choice (PPO) (plan 033) | Clover Health Choice Value (PPO) (plan 034) |
| | **Out-of-Network**:<br>35% Coinsurance for all preventive services covered under Original Medicare.<br><br>Any additional preventive services approved by Medicare during the contract year will be covered. | **Out-of-Network**:<br>35% Coinsurance for all preventive services covered under Original Medicare.<br><br>Any additional preventive services approved by Medicare during the contract year will be covered. |
| Emergency Care | **In-and-Out-of-Network**:<br>$90 Copay per visit.<br><br>Copay is waived if you are admitted to the hospital within 24 hours. | **In-and-Out-of-Network**:<br>$90 Copay per visit.<br><br>Copay is waived if you are admitted to the hospital within 24 hours. |
| Urgently Needed Services | **In-and-Out-of-Network**:<br>$25 Copay per visit.<br><br>Copay is waived if you are admitted to the hospital within 24 hours. | **In-and-Out-of-Network**:<br>$25 Copay per visit.<br><br>Copay is waived if you are admitted to the hospital within 24 hours. |
| **Diagnostic Services / Labs / Imaging** | **In-Network**:<br>**Diagnostic tests and procedures - Office setting or imaging center: up to a $40 copay**<br><br>**Diagnostic tests and procedures - Outpatient facility: $150 copay**<br><br>**Labs services: $0 copay**<br><br>**Advanced Radiology (such as MRI, PET, CT, Nuclear medicine) - office setting or imaging center: up to a $85 copay**<br><br>**Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine) - outpatient facility: $150 copay**<br><br>**X-rays services: $30 copay**<br><br>**Therapeutic radiology (radiation): 20% coinsurance** | **In-Network**:<br>**Diagnostic tests and procedures - Office setting or imaging center: up to a $40 copay**<br><br>**Diagnostic tests and procedures - Outpatient facility: $150 copay**<br><br>**Labs services: $0 copay**<br><br>**Advanced Radiology (such as MRI, PET, CT, Nuclear medicine) - office setting or imaging center: up to a $85 copay**<br><br>**Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine) - outpatient facility: $150 copay**<br><br>**X-rays services: $15 copay**<br><br>**Therapeutic radiology (radiation): 20% coinsurance** |

| SECTION II - SUMMARY OF BENEFITS | | |
|---|---|---|
| | Clover Health Choice (PPO) (plan 033) | Clover Health Choice Value (PPO) (plan 034) |
| | **Out-of-Network**:<br>Diagnostic tests and procedures - imaging center: up to a 35% coinsurance<br>Diagnostic tests and procedures - Office setting: $50 copay<br>Diagnostic tests and procedures - Outpatient facility: $175 copay<br><br>Labs services: $20 copay<br>Advanced Radiology (such as MRI, PET, CT, Nuclear medicine) - imaging center: up to a 35% coinsurance<br>Advanced Radiology (such as MRI, PET, CT, Nuclear medicine) - office setting: $100 copay<br>Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine) - outpatient facility: $250 copay<br>X-rays services: 35% coinsurance<br>Therapeutic radiology (radiation): 35% coinsurance | **Out-of-Network**:<br>Diagnostic tests and procedures - imaging center: up to a 35% coinsurance<br>Diagnostic tests and procedures - Office setting: $50 copay<br>Diagnostic tests and procedures - Outpatient facility: $175 copay<br><br>Labs services: $20 copay<br>Advanced Radiology (such as MRI, PET, CT, Nuclear medicine) - imaging center: up to a 35% coinsurance<br>Advanced Radiology (such as MRI, PET, CT, Nuclear medicine) - office setting: $100 copay<br>Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine) - outpatient facility: $250 copay<br>X-rays services: 35% coinsurance<br>Therapeutic radiology (radiation): 35% coinsurance |
| Hearing Services | **In-Network**:<br>Medicare-covered diagnostic hearing exam: $20 copay<br><br>Routine hearing exam (1 per calendar year): $0 copay<br><br>Hearing aids (up to 2 aids per calendar year - one per ear per year):<br><br>$699 copay for Advanced aids through a TruHearing provider<br><br>$999 copay for Premium aids through a TruHearing provider<br><br>**Out-of-Network**:<br>Medicare-covered diagnostic hearing exam: $30 copay<br><br>Routine hearing exam (1 per calendar year): 35% coinsurance | **In-Network**:<br>Medicare-covered diagnostic hearing exam: $0 copay<br><br>Routine hearing exam (1 per calendar year): $0 copay<br><br>Hearing aids (up to 2 aids per calendar year - one per ear per year):<br><br>$699 copay for Advanced aids through a TruHearing provider<br><br>$999 copay for Premium aids through a TruHearing provider<br><br>**Out-of-Network**:<br>Medicare-covered diagnostic hearing exam: $20 copay<br><br>Routine hearing exam (1 per calendar year): 35% coinsurance |

| SECTION II - SUMMARY OF BENEFITS | | |
|---|---|---|
| | Clover Health Choice (PPO) (plan 033) | Clover Health Choice Value (PPO) (plan 034) |
| | Hearing aids (up to 2 aids per calendar year - one per ear per year):<br><br>$999 copayment per aid | Hearing aids (up to 2 aids per calendar year - one per ear per year):<br><br>$999 copayment per aid |
| **Dental Services** | **In-Network**:<br>Medicare Covered: $0 Copay. During an inpatient acute stay if medically necessary. Inpatient hospital copay rules apply.<br><br>Preventive dental services:<br>• Oral exam (for up to 2 per calendar year): $0 Copay.<br>• Cleaning (for up to 2 per calendar year): $0 Copay.<br>• Fluoride treatment (2 per calendar year): $0 Copay.<br>• Dental X-rays (1 per calendar year): $0 Copay.<br><br>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:<br>• Restorative services<br>• Endodontics<br>• Periodontics<br>• Extractions<br>• Prosthodontics, Other Oral/ Maxillofacial Surgery, and Other Services<br><br>**Out-of-Network**:<br>Medicare Covered: $20 Copay during an inpatient acute stay if medically necessary. Inpatient hospital copay rules apply. | **In-Network**:<br>Medicare Covered: $0 Copay. During an inpatient acute stay if medically necessary. Inpatient hospital copay rules apply.<br><br>Preventive dental services:<br>• Oral exam (for up to 2 per calendar year): $0 Copay.<br>• Cleaning (for up to 2 per calendar year): $0 Copay.<br>• Fluoride treatment (2 per calendar year): $0 Copay.<br>• Dental X-rays (1 per calendar year): $0 Copay.<br><br>Comprehensive dental services: Plan covers up to $2000 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:<br>• Restorative services<br>• Endodontics<br>• Periodontics<br>• Extractions<br>• Prosthodontics, Other Oral/ Maxillofacial Surgery, and Other Services<br><br>**Out-of-Network**:<br>Medicare Covered: $20 Copay during an inpatient acute stay if medically necessary. Inpatient hospital copay rules apply. |

| SECTION II - SUMMARY OF BENEFITS | | |
|---|---|---|
| | Clover Health Choice (PPO) (plan 033) | Clover Health Choice Value (PPO) (plan 034) |
| | Preventive dental services:<br>• Oral exam (for up to 2 per calendar year): $0 Copay.<br>• Cleaning (for up to 2 per calendar year): $0 Copay.<br>• Fluoride treatment (2 per calendar year): $0 Copay.<br>• Dental X-rays (1 per calendar year): $0 Copay.<br><br>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:<br>• Restorative services<br>• Endodontics<br>• Periodontics<br>• Extractions<br>• Prosthodontics, Other Oral/ Maxillofacial Surgery, and Other Services<br><br>Supplemental dental benefits should be obtained from a provider in the DentaQuest network. | Preventive dental services:<br>• Oral exam (for up to 2 per calendar year): $0 Copay.<br>• Cleaning (for up to 2 per calendar year): $0 Copay.<br>• Fluoride treatment (2 per calendar year): $0 Copay.<br>• Dental X-rays (1 per calendar year): $0 Copay.<br><br>Comprehensive dental services: Plan covers up to $2000 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:<br>• Restorative services<br>• Endodontics<br>• Periodontics<br>• Extractions<br>• Prosthodontics, Other Oral/ Maxillofacial Surgery, and Other Services<br><br>Supplemental dental benefits should be obtained from a provider in the DentaQuest network. |
| Vision Services | **In-Network:**<br>Medicare-covered exam to diagnose and treat diseases and conditions of the eye: $20 Copay.<br><br>Routine eye exam (1 per calendar year): $0 Copay.<br><br>Medicare-covered eyeglasses or contact lenses (1 pair after each cataract surgery): $0 Copay.<br><br>Routine eyeglasses (lenses and/or frames) or contacts: $0 Copay. | **In-Network:**<br>Medicare-covered exam to diagnose and treat diseases and conditions of the eye: $0 Copay.<br><br>Routine eye exam (1 per calendar year): $0 Copay.<br><br>Medicare-covered eyeglasses or contact lenses (1 pair after each cataract surgery): $0 Copay.<br><br>Routine eyeglasses (lenses and/or frames) or contacts: $0 Copay. |

| SECTION II - SUMMARY OF BENEFITS | | |
|---|---|---|
| | Clover Health Choice (PPO) (plan 033) | Clover Health Choice Value (PPO) (plan 034) |
| | Plan will pay up to $100 per calendar year for combined in & out-of-network routine contacts or eyeglasses (lenses and/or frames).<br><br>**Out-of-Network:**<br>Medicare-covered exam to diagnose and treat diseases and conditions of the eye: $30 Copay.<br><br>Routine eye exam (1 per calendar year): $0 Copay.<br><br>Medicare-covered eyeglasses or contact lenses (1 pair after each cataract surgery): $0 Copay.<br><br>Routine eyeglasses (lenses and/or frames) or contacts: $0 Copay.<br><br>Plan will pay up to $100 per calendar year for combined in-and-out-of-network routine contacts or eyeglasses (lenses and/or frames).<br><br>Supplemental routine vision benefits should be obtained from a provider in the EyeQuest network. | Plan will pay up to $250 per calendar year for combined in & out-of-network routine contacts or eyeglasses (lenses and/or frames).<br><br>**Out-of-Network:**<br>Medicare-covered exam to diagnose and treat diseases and conditions of the eye: $20 Copay.<br><br>Routine eye exam (1 per calendar year): $0 Copay.<br><br>Medicare-covered eyeglasses or contact lenses (1 pair after each cataract surgery): $0 Copay.<br><br>Routine eyeglasses (lenses and/or frames) or contacts: $0 Copay.<br><br>Plan will pay up to $250 per calendar year for combined in-and-out-of-network routine contacts or eyeglasses (lenses and/or frames).<br><br>Supplemental routine vision benefits should be obtained from a provider in the EyeQuest network. |
| **Mental Health Services** | **In-Network:**<br>**Outpatient group therapy visit: $20 Copay.**<br><br>**Individual therapy visit: $20 Copay.**<br><br>**Out-of-Network:**<br>Outpatient group therapy visit: $30 Copay.<br><br>Individual therapy visit: $30 Copay. | **In-Network:**<br>**Outpatient group therapy visit: $0 Copay.**<br><br>**Individual therapy visit: $0 Copay.**<br><br>**Out-of-Network:**<br>Outpatient group therapy visit: $20 Copay.<br><br>Individual therapy visit: $20 Copay. |

| SECTION II - SUMMARY OF BENEFITS | | |
|---|---|---|
| | Clover Health Choice (PPO) (plan 033) | Clover Health Choice Value (PPO) (plan 034) |
| **Skilled Nursing Facility (SNF)** | **In-Network**:<br>**Days 1-20: $0 Copay per day.**<br>**Days 21-100: $178 Copay per day.**<br><br>**Out-of-Network:**<br>35% coinsurance per stay<br><br>Our plan covers up to 100 days each benefit period. No prior hospitalization stay is required. | **In-Network**:<br>**Days 1-20: $0 Copay per day.**<br>**Days 21-100: $178 Copay per day.**<br><br>**Out-of-Network:**<br>35% coinsurance per stay<br><br>Our plan covers up to 100 days each benefit period. No prior hospitalization stay is required. |
| **Physical Therapy** | **In-Network**:<br>**Physical therapy and speech and language therapy visit: $20 Copay.**<br><br>**Occupational therapy visit: $20 Copay.**<br><br>**Out-of-Network:**<br>Physical therapy and speech and language therapy visit: 35% coinsurance.<br><br>Occupational therapy visit: 35% coinsurance | **In-Network**:<br>**Physical therapy and speech and language therapy visit: $20 Copay.**<br><br>**Occupational therapy visit: $20 Copay.**<br><br>**Out-of-Network:**<br>Physical therapy and speech and language therapy visit: 35% coinsurance.<br><br>Occupational therapy visit: 35% coinsurance |
| **Ambulance** | **In-Network**:<br>**Ground Ambulance: $300 Copay.**<br><br>**Air Ambulance: $300 Copay.**<br><br>**Out-of-Network**:<br>Ground Ambulance: $300 Copay.<br><br>Air Ambulance: $300 Copay. | **In-Network**:<br>**Ground Ambulance: $225 Copay.**<br><br>**Air Ambulance: $225 Copay.**<br><br>**Out-of-Network**:<br>Ground Ambulance: $225 Copay.<br><br>Air Ambulance: $225 Copay. |
| **Transportation** | Not Covered. | **$0 copay for up to 24 one-way non-emergent trips within the plan service area to any health-related location. Each one-way trip must not exceed 50 miles.** |

| SECTION II - SUMMARY OF BENEFITS | | |
|---|---|---|
| | Clover Health Choice (PPO) (plan 033) | Clover Health Choice Value (PPO) (plan 034) |
| **Medicare Part B Drugs** | **In-Network**:<br>**For Part B drugs such as chemotherapy drugs: 20% Coinsurance.**<br><br>**Other Part B drugs: 20% Coinsurance.**<br><br>**Out-of-Network:**<br>For Part B drugs such as chemotherapy drugs: 35% Coinsurance.<br><br>Other Part B drugs: 35% Coinsurance. | **In-Network**:<br>**For Part B drugs such as chemotherapy drugs: 20% Coinsurance.**<br><br>**Other Part B drugs: 20% Coinsurance.**<br><br>**Out-of-Network:**<br>For Part B drugs such as chemotherapy drugs: 35% Coinsurance.<br><br>Other Part B drugs: 35% Coinsurance. |
| **Ambulatory Surgery Center** | **In-Network**:<br>**$325 Copay.**<br><br>**Out-of-Network:**<br>35% Coinsurance. | **In-Network**:<br>**$250 Copay.**<br><br>**Out-of-Network:**<br>35% Coinsurance. |
| Foot Care (podiatry services) | **In-Network**:<br>Medicare-covered foot care: $20 Copay.<br><br>Routine foot care: Not covered.<br><br>**Out-of-Network:**<br>Medicare-covered foot care: $30 Copay.<br><br>Routine foot care: Not covered. | **In-Network**:<br>Medicare-covered foot care: $0 Copay.<br><br>Routine foot care: Not covered.<br><br>**Out-of-Network:**<br>Medicare-covered foot care: $20 Copay.<br><br>Routine foot care: Not covered. |
| **Durable Medical Equipment** | **In-Network**:<br>**20% Coinsurance.**<br><br>**Out-of-Network:**<br>20% Coinsurance. | **In-Network**:<br>**20% Coinsurance.**<br><br>**Out-of-Network:**<br>20% Coinsurance. |

| SECTION II - SUMMARY OF BENEFITS | | |
|---|---|---|
| | Clover Health Choice (PPO) (plan 033) | Clover Health Choice Value (PPO) (plan 034) |
| **Prosthetic Devices** ***(braces, artificial limbs, etc.)*** | **In-Network**:<br>**Prosthetic devices: 20% Coinsurance.**<br><br>**Related medical supplies: 20% Coinsurance.**<br><br>**Out-of-Network:**<br>Prosthetic devices: 20% Coinsurance.<br><br>Related medical supplies: 20% Coinsurance. | **In-Network**:<br>**Prosthetic devices: 20% Coinsurance.**<br><br>**Related medical supplies: 20% Coinsurance.**<br><br>**Out-of-Network:**<br>Prosthetic devices: 20% Coinsurance.<br><br>Related medical supplies: 20% Coinsurance. |
| Diabetes Supplies and Services | **In-Network**:<br>Diabetes monitoring supplies from a pharmacy: $0 Copay.<br><br>Preferred products = One-Touch Test Strips & monitors and Accu-Chek Test Strips & monitors.<br><br>Diabetes monitoring supplies from a DME supplier: 20% Coinsurance.<br><br>Diabetes self-management training: $0 Copay.<br><br>Therapeutic shoes or inserts: $0 Copay.<br><br>**Out-of-Network**:<br>Diabetes monitoring supplies: 35% Coinsurance.<br><br>Diabetes self-management training: $0 Copay.<br><br>Therapeutic shoes or inserts: 35% Coinsurance. | **In-Network**:<br>Diabetes monitoring supplies from a pharmacy: $0 Copay.<br><br>Preferred products = One-Touch Test Strips & monitors and Accu-Chek Test Strips & monitors.<br><br>Diabetes monitoring supplies from a DME supplier: 20% Coinsurance.<br><br>Diabetes self-management training: $0 Copay.<br><br>Therapeutic shoes or inserts: $0 Copay.<br><br>**Out-of-Network**:<br>Diabetes monitoring supplies: 35% Coinsurance.<br><br>Diabetes self-management training: $0 Copay.<br><br>Therapeutic shoes or inserts: 35% Coinsurance. |
| Wellness Program | $0 copay for a gym membership through SilverSneakers®. | $0 copay for a gym membership through SilverSneakers®. |

| SECTION II - SUMMARY OF BENEFITS | | |
|---|---|---|
| | Clover Health Choice (PPO) (plan 033) | Clover Health Choice Value (PPO) (plan 034) |
| Over-the-Counter | You pay a $0 copay for select OTC products through our mail order service, up to a $75 allowance.<br><br>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.<br><br>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:**<br><br>20% Coinsurance. | **In-and-Out-of-Network:**<br><br>20% Coinsurance. |
| Lab services and tests for COVID-19 | **In-and-Out-of-Network:**<br><br>$0 Copay. | **In-and-Out-of-Network:**<br><br>$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.<br><br>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.<br><br>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** | Because there is no deductible for the plan, this payment stage does not apply to you. | Because there is no deductible for the plan, this payment stage does not apply to you. |
| **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. |

## SECTION II - SUMMARY OF BENEFITS

| | Clover Health Choice (PPO) (plan 033) | Clover Health Choice Value (PPO) (plan 034) |
|---|---|---|

**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) | 33% coinsurance |

**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) | 33% coinsurance |

| 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) | 33% coinsurance |

| 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) | 33% coinsurance |

| 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) | 33% coinsurance |

| 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) | 33% coinsurance |

## SECTION II - SUMMARY OF BENEFITS

| | Clover Health Choice (PPO) (plan 033) | Clover Health Choice Value (PPO) (plan 034) |
|---|---|---|

**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) | 33% coinsurance |

**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) | 33% 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) | 33% 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) | 33% 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) | 33% 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) | 33% coinsurance |

## SECTION II - SUMMARY OF BENEFITS

<table>
<tr><th></th><th>Clover Health Choice (PPO)<br>(plan 033)</th><th>Clover Health Choice Value (PPO)<br>(plan 034)</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>33% coinsurance</td></tr></table></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>33% 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></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.<br><br>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.</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.<br><br>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.</td></tr>
<tr><td>Catastrophic Amount</td><td>After your yearly out-of-pocket drug costs reach $7,050, you pay the greater of:<ul><li>$3.95 copay for generic (including brand drugs treated as generic) and a $9.85 copayment for all other drugs, or</li><li>5% of the cost.</li></ul></td><td>After your yearly out-of-pocket drug costs reach $7,050, you pay the greater of:<ul><li>$3.95 copay for generic (including brand drugs treated as generic) and a $9.85 copayment for all other drugs, or</li><li>5% of the cost.</li></ul></td></tr>
</table>

| SECTION II - SUMMARY OF BENEFITS | | |
|---|---|---|
| | Clover Health Choice (PPO) (plan 033) | Clover Health Choice Value (PPO) (plan 034) |
| **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. |

## 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 033)** and **Clover Health Choice Value (PPO) (plan 034)** 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 1st 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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