Clover Health

Arizona
2021 Summary of Benefits

Clover Health Choice (PPO) (040)
Available in the following county: Pima

2021 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

Clover Health Choice (PPO) (Plan 040)

January 1, 2021 – December 31, 2021

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

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

Sections in this booklet

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

This document may be available in a non-English language. For additional information, call us at 1-888-778-1478 (TTY: 711).

Things to Know About Clover Health Choice (PPO)

Hours of Operation & Contact Information

- From October 1 to March 31 we're open 8 a.m. – 8 p.m. local time, 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m. local time, Monday through Friday, alternate technologies (for example, voicemail) will be used on the weekends and holidays.
- If you are a member of this plan, call us at 1-888-778-1478, TTY: 711.
- If you are not a member of this plan, call us at 1-888-466-5044, TTY: 711.
- Our website: www.cloverhealth.com.

Who can join?

To join **Clover Health Choice (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and must live in our service area. Our service area includes the following county in Arizona: Pima.

What do we cover?

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

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

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

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

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

How will I determine my drug costs?

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

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

SECTION II - SUMMARY OF BENEFITS Clover Health Choice (PPO) (Plan 040)	
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	You do not pay a separate monthly plan premium for Clover Health Choice (PPO). You must continue to pay your Medicare Part B premium.
Deductible	Medical Deductible: Not Applicable. Prescription Drugs Deductible: Not Applicable.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $3,400 for services you receive from in-network providers. • $3,400 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. The amount you pay for some services does not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Evidence of Coverage (EOC). Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
COVERED MEDICAL AND HOSPITAL BENEFITS Covered services that need approval in advance are marked in bold in the Benefits Chart below.	
Inpatient Hospital	**In-Network:** **Days 1-5: $200 Copay per day.** **Days 6-365: $0 Copay per day.** **Out-of-Network:** Days 1-5: $320 Copay per day. Days 6-365: $0 Copay per day.
Outpatient Hospital	**In-Network:** **Outpatient Surgery: $150 Copay.** **Surgery copay will be waived if there is a surgical procedure during a screening colonoscopy.** **Out-of-Network:** Outpatient Surgery: $250 copay.
Doctor's Office Visits	**In-Network:** Primary care physician visit: $0 Copay. Specialist visit: $15 Copay.

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	Out-of-Network: Primary care physician visit: $5 copay. Specialist visit: $30 copay.
Preventive Care *(e.g., flu vaccine, diabetic screenings)*	**In-Network:** $0 Copay for all preventive services covered under Original Medicare. **Out-of-Network:** 35% Coinsurance 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-Network and Out-of-Network:** $90 Copay per visit. Copay is waived if you are admitted to the hospital within 24 hours.
Urgently Needed Services	**In-Network and Out-of-Network:** $25 Copay per visit. Copay is waived if you are admitted to the hospital within 24 hours.
Diagnostic Services / Labs/ Imaging	**In-Network:** **Diagnostic tests and procedures - Office setting or imaging center: $50 copay** **Diagnostic tests and procedures - Outpatient facility: $150 copay** **Labs services: $0 copay** **Labs services and tests for COVID-19: $0 copay** **Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine) – office setting or imaging center: up to $85 copay** **Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine) - outpatient facility: $150 copay** **X-rays services: $30 copay** **Therapeutic radiology (radiation): 20% coinsurance**

SECTION II - SUMMARY OF BENEFITS Clover Health Choice (PPO) (Plan 040)	
	Out-of-Network: Diagnostic tests and procedures - Office setting, or imaging center: up to $65 copay Diagnostic tests and procedures - outpatient facility: $175 copay Labs services: $20 copay Labs services and tests for COVID-19: $0 copay Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine) - office setting, or imaging center: up to a $100 copay Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine) - outpatient facility: $250 copay X-rays: 35% coinsurance Therapeutic radiology (radiation): 35% coinsurance
Hearing Services	**In-Network:** Medicare-covered diagnostic hearing exam: $15 copay Routine hearing exam (1 per calendar year): $0 copay Hearing aids (up to 2 aids per calendar year - one per ear per year): $699 copay for Advanced aids through a TruHearing provider $999 copay for Premium aids through a TruHearing provider **Out-of-Network:** Medicare-covered diagnostic hearing exam: $30 copay Routine hearing exam (1 per calendar year): 35% coinsurance Hearing aids (up to 2 aids per calendar year - one per ear per year): $999 copay per aid
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 (2 per calendar year): $0 Copay. • Dental X-rays (1 per calendar year): $0 Copay. • Fluoride treatment (2 per calendar year): $0 Copay. **Comprehensive dental services:**

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	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 (2 per calendar year): $0 Copay. • Fluoride treatment (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 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: $15 Copay. Routine eye exam (1 per calendar year): $0 Copay. Medicare-covered eyeglasses or contact lenses (1 pair after each cataract surgery): $0 Copay. Routine eyeglasses (lenses and/or frames) or contacts: $0 Copay. Plan will pay up to $100 per calendar year for combined in & out-of-network routine contacts or eyeglasses (lenses and/or frames). Supplemental routine vision benefits should be obtained from a provider in the EyeQuest network.

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	Out-of-Network: Medicare-covered exam to diagnose and treat diseases and conditions of the eye: $30 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 $100 per calendar year for combined in & out-of-network routine contacts or eyeglasses (lenses and/or frames). Supplemental routine vision benefits should be obtained from a provider in the EyeQuest network. Members are responsible for any amount above EyeQuest's contracted rates for covered services obtained from providers outside the EyeQuest network.
Mental Health Services	**In-Network:** **Outpatient group therapy visit: $15 Copay.** **Individual therapy visit: $15 Copay.** **Out-of-Network:** Outpatient group therapy visit: $30 copay. Individual therapy visit: $30 copay.
Skilled Nursing Facility (SNF)	**In-Network:** **Days 1-20: $0 Copay per day.** **Days 21-100: $178 Copay per day.** **Out-of-Network:** 35% Coinsurance per stay 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: $15 Copay.** **Occupational therapy visit: $15 Copay.** **Out-of-Network:** Physical therapy and speech and language therapy visit: 35% Coinsurance. Occupational therapy visit: 35% Coinsurance.
Ambulance	**In-Network:** **Ground Ambulance: $220 Copay.**

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	Air Ambulance: $220 Copay. **Out-of-Network:** Ground Ambulance: $220 Copay. Air Ambulance: $220 Copay.
Transportation	**$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.**
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: 35% Coinsurance. Other Part B drugs: 35% Coinsurance.
Ambulatory Surgery Center	**In-Network:** **$200 copay** **Out-of-Network:** 35% Coinsurance
Foot Care *(podiatry services)*	**In-Network:** Medicare-covered foot care: $15 Copay. Routine foot care: Not covered **Out-of-Network:** Medicare-covered foot care: $30 copay. Routine foot care: Not covered
Durable Medical Equipment	**In-Network:** **20% Coinsurance.** **Out-of-Network:** 35% Coinsurance.

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Prosthetic Devices ***(braces, artificial limbs, etc.)***	**In-Network:** **Prosthetic devices: 20% Coinsurance.** **Related medical supplies: 20% Coinsurance.** **Out-of-Network:** Prosthetic devices: 35% Coinsurance. Related medical supplies: 35% 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. **Out-of-Network:** Diabetes monitoring supplies from a pharmacy: 35% coinsurance Diabetes monitoring supplies from a DME supplier: 35% coinsurance Diabetes self-management training: $0 Copay. Therapeutic shoes or inserts: 35% Coinsurance.
Wellness Program	$0 copay for a gym membership through SilverSneakers®.
Over-the-Counter	You pay a $0 copay for select OTC products through our mail order service, up to a $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.
PRESCRIPTION DRUG BENEFITS	
Deductible Stage	Because there is no deductible for the plan, this payment stage does not apply to you.

SECTION II - SUMMARY OF BENEFITS

Clover Health Choice (PPO) (Plan 040)

Initial Coverage

You pay the following until your total yearly drug costs reach $4,130. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

Standard Retail Cost-Sharing

Tier	30 day supply	60 day supply	100 day supply
Tier 1 (Preferred Generic)	$7 copay	$10 copay	$5 copay
Tier 2 (Generic)	$15 copay	$30 copay	$45 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$141 copay
Tier 4 (Non-Preferred Drug)	$100 copay	$200 copay	$300 copay
Tier 5 (Specialty Tier)	33% coinsurance	33% coinsurance	33% coinsurance

Preferred Retail Cost-Sharing

Tier	30 day supply	60 day supply	100 day supply
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$10 copay	$20 copay	$30 copay
Tier 3 (Preferred Brand)	$40 copay	$80 copay	$120 copay
Tier 4 (Non-Preferred Drug)	$95 copay	$190 copay	$285 copay
Tier 5 (Specialty Tier)	33% coinsurance	33% coinsurance	33% coinsurance

Mail Order

Tier	100 day supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$0 copay
Tier 3 (Preferred Brand)	$110 copay
Tier 4 (Non-Preferred Drug)	$275 copay
Tier 5 (Specialty Tier)	33% coinsurance

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

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	Please call us or see the plan's **"Evidence of Coverage"** on our website (www.cloverhealth.com) for complete information about your costs for covered drugs.
Coverage Gap	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap.
Catastrophic Amount	After your yearly out-of-pocket drug costs reach $6,550, you pay the greater of: • $3.70 copay for generic (including brand drugs treated as generic) and a $9.20 copayment for all other drugs, or • 5% of the cost.

DISCLAIMERS

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

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

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

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

You must continue to pay your Medicare Part B premium.

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

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

Health coverage is offered by Clover Insurance Company.

We're here to help.

1-888-778-1478 (TTY 711)

8 am–8 pm local time, 7 days/week*

Visit us at cloverhealth.com/enroll

*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.

Clover Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-778-1478 (TTY 711). Clover Health cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: Si usted habla español, tenemos servicios de asistencia lingüística disponibles para usted sin costo alguno. Llame al 1-888-778-1478 (TTY 711). Clover Health 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障 或性别而歧視任何人 。 小贴士：如果您说普通话，欢迎使用免费语言协助服务。请拨 1-888-778-1478 (TTY 711)。

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