Clover Health

New Jersey
2027 Summary of Benefits

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

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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, visit **cloverhealth.com/eoc** or call us and ask for the **"Evidence of Coverage."**

Hours of Operation & Contact Information

- From October 1 to March 31 we're open 8 am–8 pm local time, 7 days a week.
- From April 1 to September 30, we're open 8 am–8 pm 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**
- This document may be available in a non-English language. For additional information, call us at **1-888-778-1478 (TTY/TDD: 711)**.

Who can join?

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

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits. 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/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 **www.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, and Catastrophic Coverage. For additional information, review Chapter 6 of your Evidence of 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 Value (PPO) (Plan 007)

Service Areas

Clover Health Choice Value (PPO) (Plan 007) includes the following counties in New Jersey: Atlantic, Bergen, Essex, Hudson, Mercer, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex, and Union.

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

Monthly Plan Premium (includes both medical and drug)

$36.30 per month. In addition, you must keep paying your Medicare Part B premium.

Part B Premium Buy-Down

Not applicable.

Medical Deductible

No deductible for medical. See Prescription drugs section for Part D deductible.

Maximum Out-of-Pocket Responsibility (does not include Part D prescription drugs)

Your yearly maximums in this plan:

- $9,850 for in-network providers
- $14,800 for in- and out-of-network providers combined

Once you pay this amount in deductibles, copays, and coinsurance for services, your plan pays 100% for covered health services.

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).

COVERED MEDICAL AND HOSPITAL BENEFITS

Covered services that need approval in advance are marked in bold font in the Benefits Chart on the following pages.

SECTION II – SUMMARY OF BENEFITS

Clover Health Choice Value (PPO) (Plan 007)	
Inpatient Hospital	
In-Network: **Days 1–6: $350 copay per day** **Days 7–365: $0 copay per day**	Out-of-Network: Days 1–6: $555 copay per day Days 7–365: $0 copay per day
Outpatient Hospital	
In-Network: **Outpatient surgery: $250 copay**	Out-of-Network: Outpatient surgery: $350 copay
Ambulatory Surgery Center	
In-Network: **$175 copay**	Out-of-Network: $250 copay
Doctor's Office Visits	
In-Network: Primary care physician visit: $0 copay Specialist visit: $2 copay	Out-of-Network: Primary care physician visit: $0 copay Specialist visit: $15 copay
Preventive Care *(e.g., Wellness visits, Diabetes related services, Tests & screenings)*	
In-Network and Out-of-Network: $0 copay for all preventive services covered under Original Medicare. Any additional preventive services approved by Medicare during the contract year will be covered.	
Emergency Care	
In-Network and Out-of-Network: $115 copay per visit. Copay is waived if you are admitted to the hospital within 24 hours. Worldwide Coverage: $115 copay Plan covers up to $50,000 per calendar year for worldwide emergency care, urgent care, and ambulance services. Applicable copays apply.	
Urgently Needed Services	
In-Network and Out-of-Network: $35 copay per visit. Copay is waived if you are admitted to the hospital within 24 hours. Worldwide Coverage: $40 copay Plan covers up to $50,000 per calendar year for worldwide emergency care, urgent care, and ambulance services. Applicable copays apply.	

SECTION II – SUMMARY OF BENEFITS

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Diagnostic Services / Labs/ Imaging

In-Network:	Out-of-Network:
Diagnostic tests and procedures – **At an office: $40 copay** **At a freestanding facility:** **$150 copay** **At a non-freestanding facility:** **$175 copay** $0 copay for COVID tests $0 copay for diagnostic colonoscopy **Labs:** **$0 copay for services at LabCorp or Quest** **$10 copay for services at non-LabCorp or Quest** **Advanced Radiology:** **At an office: $40 copay** **At a freestanding facility:** **$150 copay** **At a non-freestanding facility:** **$175 copay** X-rays: $15 copay **Therapeutic radiology (radiation):** **20% coinsurance**	Diagnostic tests and procedures: At an office: $60 copay At a freestanding facility: $250 copay At a non-freestanding facility: $275 copay $0 copay for COVID tests $0 copay for diagnostic colonoscopy Labs: $30 copay Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine): At an office: $60 copay At a freestanding facility: $250 copay At a non-freestanding facility: $275 copay X-rays: $30 copay Therapeutic radiology (radiation): 40% coinsurance

Hearing Services

In-Network:	Out-of-Network:
Medicare-covered diagnostic hearing exam: $2 copay Routine hearing exam (1 per calendar year): $0 copay Hearing aids (up to 2 aids per calendar year – one per ear per year): all types $499 copay for Standard aids through a TruHearing provider $699 copay for Advanced aids through a TruHearing provider $999 copay for Premium aids through a TruHearing provider	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): $5,000 copayment for each non-TruHearing hearing aid

SECTION II – SUMMARY OF BENEFITS

Clover Health Choice Value (PPO) (Plan 007)

Dental Services

In-Network:
Preventive dental services:

- Oral exam (2 per calendar year): $0 copay
- Cleaning (up to 2 per calendar year): $0 copay
- Dental X-rays (1 per calendar year): $0 copay

Supplemental comprehensive dental services with a $20 copay per service:

- Restorative services (ex: fillings, crowns)
- Endodontics (ex: root canal treatment)
- Periodontics (ex: scaling & root planing)
- Prosthodontics, fixed (ex: bridges)
- Implants Services (ex: implants & abutments)
- Oral/Maxillofacial Surgery (ex: extractions)
- Adjunctive General Services (ex: anesthesia, consultations)

Supplemental comprehensive dental services with a 50% coinsurance per service:

- Prosthodontics, removable (ex: dentures)

Out-of-Network
Preventive dental services with a 50% coinsurance per service:

- Oral exam (2 per calendar year)
- Cleaning (up to 2 per calendar year)
- Dental X-rays (1 per calendar year)

Supplemental comprehensive dental services with a 50% coinsurance per service:

- Restorative services (ex: fillings, crowns)
- Endodontics (ex: root canal treatment)
- Periodontics (ex: scaling & root planing)
- Prosthodontics, fixed (ex: bridges)
- Implants Services (ex: implants & abutments)
- Oral/Maxillofacial Surgery (ex: extractions)
- Adjunctive General Services (ex: anesthesia, consultations)
- Prosthodontics, removable (ex: dentures)

Every year, your plan covers up to $2,500 for covered dental services—you are responsible for the applicable copay/coinsurance for each service. Once your allowance is used, you will be responsible to pay for any additional dental costs for the rest of the year. The list of examples given above are not a comprehensive list of covered services.

Limitations apply; see Evidence of Coverage for more details. Cosmetic procedures such as teeth whitening are not covered.

Clover Dental is powered by NationsBenefits. You can see in- or out-of-network providers for dental services (out-of-network providers must be licensed in the U.S.), however seeing an in-network provider will result in substantially lower out-of-pocket costs for you. An out-of-network provider is not contracted with Clover Health and may bill more than what Clover Health pays for that service. You will be responsible for any applicable copay or coinsurance, plus the difference between the provider's billed amount and what Clover Health pays, even for services listed with no member cost-share. Benefits received out-of-network are subject to any benefit maximums, limitations, and/or exclusions.

SECTION II – SUMMARY OF BENEFITS

Clover Health Choice Value (PPO) (Plan 007)	
Vision Services	
In-Network: Medicare-covered exam to diagnose and treat diseases and conditions of the eye: $2 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	Out-of-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
$300 (combined in and out-of-network) vision allowance per calendar year toward the purchase and fitting of frames with lenses (1 pair per year) or contact lenses. The vision allowance can only be used one time. Any remaining benefit dollars can not be used for additional eyewear.	
Mental Health Services	
In-Network: Outpatient group therapy visit: $10 copay Individual therapy visit: $20 copay	Out-of-Network: Outpatient group therapy visit: $30 copay Individual therapy visit: $40 copay
Skilled Nursing Facility (SNF)	
In-Network: **Days 1–20: $0 copay per day** **Days 21–100: $221 copay per day**	Out-of-Network: 40% coinsurance Our plan covers up to 100 days each benefit period. No prior hospitalization stay is required.
Physical Therapy	
In-Network: **Physical therapy visit: $5 copay** **Speech and language therapy visit: $5 copay** **Occupational therapy visit: $5 copay**	Out-of-Network: Physical therapy visits: $15 copay Speech and language therapy visit: $15 copay Occupational therapy visit: $15 copay
Ambulance (domestic ground & air)	
In-Network: **$300 copay**	Out-of-Network: $300 copay
Transportation	
Not covered	

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Medicare Part B Drugs	
In-Network: **Chemotherapy: 20% coinsurance** **Other Part B drugs: 20% coinsurance** **Part B Insulin: $35 copay per month supply**	Out-of-Network: Chemotherapy: 40% coinsurance Other Part B drugs: 40% coinsurance Part B insulin: 40% coinsurance
Foot Care *(podiatry services)*	
In-Network: Medicare-covered: $5 copay Routine care: Not covered	Out-of-Network: Medicare-covered: $15 copay Routine care: Not covered
Chiropractic	
In-Network: Medicare-covered: $5 copay Routine care: Not covered	Out-of-Network: Medicare-covered: $40 copay Routine care: Not covered
Acupuncture	
In-Network: Medicare-covered: $2 copay Routine care: Not covered	Out-of-Network: Medicare-covered: $15 copay Routine care: Not covered
Durable Medical Equipment	
In-Network: **20% coinsurance**	Out-of-Network: 20% coinsurance
Prosthetic Devices *(e.g. artificial limbs, braces, etc.)*	
In-Network: **Prosthetic devices: 20% coinsurance** **Related medical supplies: 20% coinsurance**	Out-of-Network: Prosthetic devices: 20% coinsurance Related medical supplies: 20% coinsurance

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Diabetes Supplies and Services

In-Network:	Out-of-Network:
Diabetes monitoring supplies from a pharmacy: $0 copay	Diabetes monitoring supplies from a pharmacy: $0 copay
Preferred manufacturers for Blood Glucose Diabetic Testing supplies: Roche = Accu-Chek, Ascensia = Contour	Preferred manufacturers for Blood Glucose Diabetic Testing supplies: Roche = Accu-Chek, Ascensia = Contour
Quantity Limit Test strips: 100 strips per 30 days	Quantity Limit Test strips: 100 strips per 30 days
Prior Authorization: Blood Glucose Monitor	Prior Authorization: Blood Glucose Monitor
Continuous glucose monitoring (CGM) supplies: Abbott (Freestyle Libre), Dexcom	Continuous glucose monitoring (CGM) supplies: Abbott (Freestyle Libre), Dexcom
Prior Authorization and quantity limits on CGM supplies	Prior Authorization and quantity limits on CGM supplies
Diabetes monitoring supplies from a DME supplier: 20% coinsurance	Diabetes monitoring supplies from a DME supplier: 20% coinsurance
Therapeutic shoes or inserts: $0 copay	Therapeutic shoes or inserts: $0 copay

Wellness Program

In-Network:	Out-of-Network:
$0 copay for One Pass®, includes access to a participating gym network, digital fitness content, cognitive program, at-home fitness kits and social connection activities.	Up to $5 maximum reimbursement per calendar month at an out-of-network fitness center. $5 monthly maximum reimbursement applies, even if your monthly charges exceed $5. Charges must be incurred in the month claimed (up-front annual/lump-sum payments cannot be split into monthly $5 claims). Excludes non–fitness-center facilities such as martial arts, yoga/Pilates/dance/spin studios, golf/tennis/swim/racquet clubs, country/social clubs, spas, single-sport activities, and personal training.

Over-the-Counter

Up to $145 per quarter allowance for approved OTC items and specific OTC vendors. Any unused amount will not be carried over to the next quarter. Allowances start over at the beginning of each quarter.

Dialysis Services

In-Network:	Out-of-Network:
20% coinsurance	40% coinsurance

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Clover Health Choice Value (PPO) (Plan 007)

PRESCRIPTION DRUG BENEFITS

Important Message About What You Pay for Vaccines

Our plan covers most adult Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

Important Message About What You Pay for Insulin

You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Deductible Stage

There is no deductible for drugs in Tier 1 and 2. During this stage, you pay the full cost of your Tier 3, 4, and 5 drugs. You stay in this stage until you have paid $440 for your Tier 3, 4, and 5 drugs.

Initial Coverage

You pay the following until your total out-of-pocket costs reach $2,400.

Network 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)	$8 copay	$16 copay	$24 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$135 copay
Tier 4 (Non-Preferred Drug)	34% coinsurance	34% coinsurance	34% coinsurance
Tier 5 (Specialty Tier)	28% coinsurance	28% coinsurance	28% coinsurance

Mail Order

Tier	100-day supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$0 copay
Tier 3 (Preferred Brand)	$135 copay
Tier 4 (Non-Preferred Drug)	34% coinsurance
Tier 5 (Specialty Tier)	28% coinsurance

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.

Catastrophic Coverage

After your yearly out-of-pocket drug costs reach $2,400, you pay nothing for your covered Part D drugs.

SECTION II – SUMMARY OF BENEFITS

The following is not considered a plan benefit but is a reward program available to you.

REWARDS PROGRAM

Clover LiveHealthy Rewards®

Get up to $400 a year in LiveHealthy Rewards

When you enroll in your Clover Health Medicare Advantage plan, you are automatically eligible to receive reward dollars for completing simple activities. For more information, please visit cloverhealth.com/livehealthy.

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 Value (PPO) (Plan 007)** depends on contract renewal.

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

You must continue to pay your Medicare Part B premium.

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

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

Health coverage is offered by Clover Insurance Company.

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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 1 and September 30, 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.

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