Clover Health

New Jersey
2027 Summary of Benefits

Clover Health Value (HMO) (003)
Available in the following counties: Atlantic, Bergen, Essex, Hudson, Middlesex, Passaic, 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 Value (HMO) (Plan 003)**, 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.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which Clover Health authorizes use of out-of-network providers.

We cover Part D drugs.

- 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 **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 Value (HMO) (Plan 003)

Service Areas

Clover Health Value (HMO) (Plan 003) includes the following counties in New Jersey: Atlantic, Bergen, Essex, Hudson, Middlesex, Passaic, 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.

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 maximum in this plan:

- $4,500 for in-network providers

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.

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Inpatient Hospital
Days 1–6: $275 copay per day **Days 7–365: $0 copay per day**
Outpatient Hospital
Outpatient surgery: $275 copay
Ambulatory Surgery Center
$150 copay
Doctor's Office Visits
Primary care physician visit: $0 copay Specialist visit: $0 copay
Preventive Care *(e.g., Wellness visits, Diabetes related services, Tests & screenings)*
$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
$130 copay per visit. Copay is waived if you are admitted to the hospital within 24 hours. Worldwide Coverage: $130 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
$25 copay per visit. 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.

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Diagnostic Services / Labs/ Imaging
Diagnostic tests and procedures – **At an office: $50 copay** **At a freestanding facility: $100 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** **$20 copay for services at non-LabCorp or Quest** **Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine):** **At an office: $50 copay** **At a freestanding facility: $100 copay** **At a non-freestanding facility: $175 copay** X-rays: $20 copay **Therapeutic radiology (radiation): $60 copay**
Hearing Services
Medicare-covered diagnostic hearing exam: $0 copay Routine hearing exam (1 per calendar year): $0 copay Hearing aids (up to 2 aids per calendar year – one per ear per year): $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

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Dental Services

Preventive dental services:

- Oral exam (2 per calendar year):
  $0 copay
- Cleaning (for 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)

Every year, your plan covers up to $2,000 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 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.

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Vision Services
Medicare-covered exam to diagnose and treat diseases and conditions of the eye: $0 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 $250 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
Outpatient group therapy visit: $10 copay Individual therapy visit: $10 copay
Skilled Nursing Facility (SNF)
Days 1–20: $0 copay per day **Days 21–100: $221 copay per day** **Our plan covers up to 100 days each benefit period. No prior hospitalization stay is required.**
Physical Therapy
Physical therapy visit: $10 copay **Speech and language therapy visit: $10 copay** **Occupational therapy visit: $10 copay**
Ambulance (domestic ground & air)
$250 copay
Transportation
Not covered
Medicare Part B Drugs
Chemotherapy: 20% coinsurance **Other Part B drugs: 20% coinsurance** **Part B Insulin: $35 copay per month supply**
Foot Care *(podiatry services)*
Medicare-covered: $10 copay Routine care: Not covered

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Chiropractic	
Medicare-covered care: $10 copay Routine care: Not covered	
Acupuncture	
Medicare-covered care: $0 copay Routine care: Not covered	
Durable Medical Equipment	
20% coinsurance	
Prosthetic Devices *(e.g. artificial limbs, braces, etc.)*	
Prosthetic devices: 20% coinsurance **Related medical supplies: 20% coinsurance**	
Diabetes Supplies and Services	
Diabetes monitoring supplies from a pharmacy: $0 copay **Preferred manufacturers for Blood Glucose Diabetic Testing supplies: Roche = Accu-Chek, Ascensia = Contour** **Quantity Limit** **Test strips: 100 strips per 30 days** **Prior Authorization: Blood Glucose Monitor** **Continuous glucose monitoring (CGM) supplies: Abbott (Freestyle Libre), Dexcom** **Prior Authorization and quantity limits on CGM supplies** **Diabetes monitoring supplies from a DME supplier: 20% coinsurance** Therapeutic shoes or inserts: $0 copay	
Wellness Program	
In-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.	Out-of-Network: 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.

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Over-the-Counter

Up to $150 a 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

20% coinsurance

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 $200 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)	$0 copay	$0 copay	$0 copay
Tier 3 (Preferred Brand)	25% coinsurance	25% coinsurance	25% coinsurance
Tier 4 (Non-Preferred Drug)	33% coinsurance	33% coinsurance	33% coinsurance
Tier 5 (Specialty Tier)	31% coinsurance	31% coinsurance	31% coinsurance

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Mail Order

Tier	100-day supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$0 copay
Tier 3 (Preferred Brand)	25% coinsurance
Tier 4 (Non-Preferred Drug)	33% coinsurance
Tier 5 (Specialty Tier)	31% 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.

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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 Value (HMO) (Plan 003) is an HMO plan with a Medicare contract. Enrollment in **Clover Health Value (HMO) (Plan 003)** 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.

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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