Clover Health

New Jersey
2025 Summary of Benefits

Clover Health Choice (PPO) (004)
Available in the following counties: Atlantic, Bergen, Essex, Hudson, Mercer, Monmouth, Morris, Passaic, Somerset, Sussex, and Union

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

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 **1-888-778-1478 (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 (PPO) (plan 004)** and **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.

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 004)	Clover Health Choice Value (PPO) (Plan 007)
Service Areas	**Clover Health Choice (PPO) (plan 004)** includes the following counties in New Jersey: Atlantic, Bergen, Hudson, Essex, Mercer, Monmouth, Morris, Passaic, Somerset, Sussex, and Union.	**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)	No plan premium. You must continue to pay your Medicare Part B premium.	$48.30 per month. In addition, you must keep paying your Medicare Part B premium.
Part B Premium Buy-Down	If your Part B Premium is $20 or more, Clover offers a monthly $20 subsidy towards your Part B premium every month that you are enrolled. Please refer to the EOC for more information.	Not applicable
Medical Deductible	No deductible for medical. See Prescription drugs section for Part D 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: • $9,350 for In-network providers • $14,000 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).	Your yearly maximums in this plan: • $9,350 for In-network providers • $14,000 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 below.		

SECTION II – SUMMARY OF BENEFITS

	Clover Health Choice (PPO) (Plan 004)	Clover Health Choice Value (PPO) (Plan 007)
Inpatient Hospital	**In-Network:** **Days 1-6: $399 Copay per day.** **Days 7-365: $0 Copay per day.** **Out-of-Network:** Days 1-6: $549 Copay per day. Days 7-365: $0 Copay per day.	**In-Network:** **Days 1-6: $399 Copay per day.** **Days 7-365: $0 Copay per day.** **Out-of-Network:** Days 1-6: $549 Copay per day. Days 7-365: $0 Copay per day.
Outpatient Hospital	**In-Network:** **Outpatient surgery: $375 copay.** **Out-of-Network:** Outpatient surgery: $500 copay	**In-Network:** **Outpatient surgery: $250 copay.** **Out-of-Network:** Outpatient surgery: $350 copay
Ambulatory Surgery Center	**In-Network:** **$275 copay** **Out-of-Network:** $350 copay	**In-Network:** **$175 copay** **Out-of-Network:** $250 copay
Doctor's Office Visits	**In-Network:** Primary care physician visit: $0 Copay. Specialist visit: $10 Copay. **Out-of-Network:** Primary care physician visit: $0 Copay. Specialist visit: $25 Copay.	**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.	**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:** $110 Copay per visit. Copay is waived if you are admitted to the hospital within 24 hours. Worldwide Coverage: $110 Copay. Plan covers up to $50,000 per calendar year for worldwide emergency care, urgent care, and ambulance services. Applicable copays apply.	**In-Network and Out-of-Network:** $110 Copay per visit. Copay is waived if you are admitted to the hospital within 24 hours. Worldwide Coverage: $110 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		
	Clover Health Choice (PPO) (Plan 004)	Clover Health Choice Value (PPO) (Plan 007)
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 per visit. Plan covers up to $50,000 per calendar year for worldwide emergency care, urgent care, and ambulance services. Applicable copays apply.	**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.
Diagnostic Services / Labs/ Imaging	**In-Network:** **Diagnostic tests and procedures –** **At an Office: $50 copay** **At a freestanding facility: $150 copay** **At a non-freestanding facility: $200 copay** $0 copay for COVID tests $0 copay for diagnostic colonoscopy **Labs:** **$0 copay for services at LabCorp or Quest** **$15 copay for services at non-LabCorp or Quest** **Advanced Radiology:** **At an Office: $50** **At a freestanding facility: $150 copay** **At a non-freestanding facility: $200 copay** X-rays: $30 copay **Therapeutic radiology (radiation): 20% coinsurance**	**In-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** **$5 copay for services at non-LabCorp or Quest** **Advanced Radiology:** **At an Office: $40** **At a freestanding facility: $150 copay** **At a non-freestanding facility: $175 copay** X-rays: $15 copay **Therapeutic radiology (radiation): 20% coinsurance**

SECTION II – SUMMARY OF BENEFITS		
	Clover Health Choice (PPO) (Plan 004)	Clover Health Choice Value (PPO) (Plan 007)
Diagnostic Services / Labs/ Imaging	**Out-of-Network:** Diagnostic tests and procedures: At an Office: $75 At a freestanding facility: $250 At a non-freestanding facility: $300 $0 copay for COVID tests Labs: $25 copay $0 COVID labs Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine): At an Office: $75 At a freestanding facility: $250 At a non-freestanding facility: $300 X-rays: $50 copay Therapeutic radiology (radiation): 40% coinsurance	**Out-of-Network:** Diagnostic tests and procedures: At an Office: $60 At a freestanding facility: $250 At a non-freestanding facility: $275 $0 copay for COVID tests Labs: $15 copay $0 COVID labs Advanced Radiology services (such as MRI, PET, CT, Nuclear medicine): At an Office: $60 At a freestanding facility: $250 At a non-freestanding facility: $275 X-rays: $30 copay Therapeutic radiology (radiation): 40% coinsurance
Hearing Services	**In-Network:** Medicare-covered diagnostic hearing exam: $10 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 $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: $25 copay Routine hearing exam (1 per calendar year): $0 copay Hearing aids (up to 2 aids per calendar year - one per ear per year): $999 copayment per aid	**In-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 $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: $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): $999 copayment per aid

SECTION II – SUMMARY OF BENEFITS

	Clover Health Choice (PPO) (Plan 004)	Clover Health Choice Value (PPO) (Plan 007)
Dental Services	Preventive dental services: • Oral exam (1 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: • 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 • Prosthodontics, removeable (ex: dentures)	Preventive dental services: • Oral exam (1 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: • 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 • Prosthodontics, removeable (ex: dentures)

SECTION II – SUMMARY OF BENEFITS		
	Clover Health Choice (PPO) (Plan 004)	Clover Health Choice Value (PPO) (Plan 007)
Dental Services	**Out-of-Network** Supplemental comprehensive dental services with a 30% coinsurance: • 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 • Prosthodontics, removeable (ex: dentures) Our plan pays up to $2,000 every year for covered services after you pay applicable copays for each service. 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. You are responsible for any costs over this amount. This plan uses the DentaQuest PPO Network. You can see in- or out-of-network providers for dental services (out-of-network providers must be licensed in the U.S.). Note: All in-network and some out-of-network providers will bill DentaQuest directly. If you use one who won't bill DentaQuest, you can pay for covered services and ask us to reimburse you.	**Out-of-Network** Supplemental comprehensive dental services with a 30% coinsurance: • 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 • Prosthodontics, removeable (ex: dentures) Our plan pays up to $2,500 every year for covered services after you pay applicable copays for each service. 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. You are responsible for any costs over this amount. This plan uses the DentaQuest PPO Network. You can see in- or out-of-network providers for dental services (out-of-network providers must be licensed in the U.S.). Note: All in-network and some out-of-network providers will bill DentaQuest directly. If you use one who won't bill DentaQuest, you can pay for covered services and ask us to reimburse you.

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	Clover Health Choice (PPO) (Plan 004)	Clover Health Choice Value (PPO) (Plan 007)
Vision Services	**In-Network:** Medicare-covered exam to diagnose and treat diseases and conditions of the eye: $10 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. $200 (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. **Out-of-Network:** Medicare-covered exam to diagnose and treat diseases and conditions of the eye: $25 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. $200 (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.	**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. $200 (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. **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. $200 (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.

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Mental Health Services	**In-Network:** Outpatient group therapy visit: $30 Copay. Individual therapy visit: $40 Copay. **Out-of-Network:** Outpatient group therapy visit: $50 Copay. Individual therapy visit: $60 Copay.	**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: $214 Copay per day.** **Out-of-Network:** 40% Coinsurance Our plan covers up to 100 days each benefit period. No prior hospitalization stay is required.	**In-Network:** **Days 1-20: $0 Copay per day.** **Days 21-100: $214 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: $15 copay** **Speech and language therapy visit: $15 Copay** **Occupational therapy visit: $15 Copay.** **Out-of-Network:** Physical therapy visits: $25 copay Speech and language therapy visit: $25 Copay. Occupational therapy visit: $25 Copay.	**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:** **$350 Copay.** **Out-of-Network:** $350 Copay.	**In-Network:** **$350 Copay.** **Out-of-Network:** $350 Copay.
Transportation	Not covered	Not covered
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	**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

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	Clover Health Choice (PPO) (Plan 004)	Clover Health Choice Value (PPO) (Plan 007)
Foot Care *(podiatry services)*	**In-Network:** Medicare-covered: $20 Copay. Routine care: Not covered **Out-of-Network:** Medicare-covered: $40 Copay. Routine care: Not covered	**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: $15 Copay. Routine care: Not covered **Out-of-Network:** Medicare-covered: $40 Copay. Routine care: Not covered	**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: $10 Copay. Routine care: Not covered **Out-of-Network:** Medicare-covered: $25 Copay. Routine care: Not covered	**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.	**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.	**In-Network:** **Prosthetic devices: 20% Coinsurance.** **Related medical supplies: 20% Coinsurance.** **Out-of-Network:** Prosthetic devices: 20% Coinsurance. Related medical supplies: 20% 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 Therapeutic shoes or inserts: $0 Copay.	**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 Therapeutic shoes or inserts: $0 Copay.

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Diabetes Supplies and Services	**Out-of-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 Therapeutic shoes or inserts: $0 Copay.	**Out-of-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 Therapeutic shoes or inserts: $0 Copay.
Wellness Program	$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.	$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.
Over-the-Counter	Up to $110 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.	Up to $170 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:** 20% Coinsurance. **Out-of-Network:** 40% Coinsurance.	**In-Network:** 20% Coinsurance. **Out-of-Network:** 40% 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	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 $150 for your Tier 3, 4, and 5 drugs.	During this stage, you pay the full cost of your Tier 2, 3, 4, and 5 drugs. You stay in this stage until you have paid $220 for your Tier 2, 3, 4, and 5 drugs.

SECTION II – SUMMARY OF BENEFITS

<table>
<tr><th></th><th>Clover Health Choice (PPO)
(Plan 004)</th><th>Clover Health Choice Value (PPO)
(Plan 007)</th></tr>
<tr><td>Initial Coverage</td><td>You pay the following until your total out-of-pocket costs reach $2,000.
Network Cost-Sharing.
<table><tr><th>Tier</th><th>30 day supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$5 copay</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td></tr><tr><td>Tier 4 (Non-Preferred Drug)</td><td>$100 copay</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>31% coinsurance</td></tr></table><table><tr><th>Tier</th><th>60 day supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$10 copay</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>$94 copay</td></tr><tr><td>Tier 4 (Non-Preferred Drug)</td><td>$200 copay</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>31% coinsurance</td></tr></table><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>$15 copay</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>$135 copay</td></tr><tr><td>Tier 4 (Non-Preferred Drug)</td><td>$300 copay</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>31% coinsurance</td></tr></table></td><td>You pay the following until your total out-of-pocket costs reach $2,000.
Network Retail Cost-Sharing
<table><tr><th>Tier</th><th>30 day supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$5 copay</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td></tr><tr><td>Tier 4 (Non-Preferred Drug)</td><td>35% coinsurance</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>30% coinsurance</td></tr></table><table><tr><th>Tier</th><th>60 day supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$10 copay</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>$94 copay</td></tr><tr><td>Tier 4 (Non-Preferred Drug)</td><td>35% coinsurance</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>30% coinsurance</td></tr></table><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>$15 copay</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>$135 copay</td></tr><tr><td>Tier 4 (Non-Preferred Drug)</td><td>35% coinsurance</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>30% coinsurance</td></tr></table></td></tr>
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<tr><td>Initial Coverage</td><td>
Mail Order
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<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>
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<tr><td>Tier 5 (Specialty Tier)</td><td>31% coinsurance</td></tr>
</table>
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>
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>$135 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>35% coinsurance</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>30% coinsurance</td></tr>
</table>
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>Catastrophic Coverage</td><td colspan="2">After your yearly out-of-pocket drug costs reach $2,000, you pay nothing for your covered Part D drugs.</td></tr>
</table>

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.	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 (PPO) (plan 004)** and **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.

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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