MEDICARE ADVANTAGE / PDP

Plan Details

Clover Health

$37.30

Plan: **Clover Health Choice Value (PPO)**

Max Out of Pocket: **$7,550**

Annual Drug Deductible: **$445.00**

ID: **H5141-42-0**

Star Rating: **3.0**

Plan Type: **Local PPO**

Part B Reduction: **No**

Effective Year: **2021**

City: **CAMDEN**

State: **NJ**

Zip: **08104**

Chiropractic care

Out of Network: $10 copay.

In Network: Not covered. $10 copay for Medicare-covered visits.

Dental services

Out of Network: You pay nothing. (Preventive Dental)

Out of Network: $20 copay. (Comprehensive Dental)

In Network: Prophylaxis max of 2 every year. Oral exam max of 1 (see carrier information for details). Fluoride max of 2 every year. Xray max of 1 (see carrier information for details). Max of $1000 comprehensive dental benefits for this plan every year.

Diabetes supplies and services

Out of Network: You pay nothing.

In Network: You pay nothing for diabetes self-management training.

In Network: You pay nothing for Medicare-covered diabetes supplies and services or therapeutic shoes or inserts.

Diagnostic tests lab and radiology services and x-rays (Costs for these services may be different if received in an outpatient surgery setting)

Out of Network: $0-175 copay. (Diagnostic Procedures/Tests)

Out of Network: $0-40 copay. (Lab Services)

Out of Network: $0-175 copay. (Diagnostic Radiological Services)

Out of Network: $0-175 copay. (Therapeutic Radiological Services)

Out of Network: $0-175 copay. (Outpatient X-Ray Services)

In Network: $0-175 copay for Medicare-covered diagnostic procedures/tests. $0-5 copay for Medicare-covered lab services. $0-175 copay for Medicare-covered diagnostic radiological services (e.g., CT, MRI, etc). $60 copay for other Medicare-covered therapeutic radiological services. $30 copay for Medicare-covered x-rays.

Doctor's office visits

Out of Network: You pay nothing. (Primary Care Physician Services)

Out of Network: $10 copay. (Physician Specialist Services)

In Network: Primary Physician: $0 copay Specialist Physician: $10 copay

Durable medical equipment (wheelchairs oxygen etc.)

Out of Network: 30% coinsurance.

In Network: 20% per item

Foot care (podiatry services)

Out of Network: $10 copay.

In Network: $10 copay for Medicare-covered visits.

Hearing services

Out of Network: $10 copay. (Hearing Exams)

Out of Network: You pay nothing. (Hearing Exams)

Out of Network: $999 copay. (Hearing Aids)

In Network: $699-999 copay for hearing aids (all types). Hearing aid max of 2 every year. Routing hearing exam max of 1 every year.

Home health care

Out of Network: 30% coinsurance.

In Network: You pay nothing

Mental health care

Out of Network: $10 copay.

Out of Network: $345 copay for days 1-5 $0 copay for days 6-90

In Network: $225 copay for days 1-5 $0 copay for days 6-90

Outpatient rehabilitation

Out of Network: $50 copay. (Cardiac Rehabilitation Services)

Out of Network: $50 copay. (Intensive Cardiac Rehabilitation Services)

Out of Network: $50 copay. (Pulmonary Rehabilitation Services)

Out of Network: $50 copay. (Occupational Therapy Services)

Out of Network: $50 copay. (Physical Therapy and Speech-Language Pathology Services)

In Network: $10 copay for Medicare-covered cardiac rehabilitation services. $10 copay for Medicare-covered intensive cardiac rehabilitation services. $10 copay for Medicare-covered pulmonary rehabilitation services.

In Network: $10 copay for physical therapy and speech therapy. $10 copay for occupational therapy.

Outpatient substance abuse

Out of Network: $10 copay.

In Network: $10 copay for group visits. $10 copay for individual visits

Outpatient surgery

Out of Network: $160 copay. (Ambulatory Surgical Center (ASC) Services)

In Network: $225 per visit

Over-the-counter items

Out of Network: You pay nothing. Plan benefit max of $100.

In Network: Max of $100 benefit for this plan every three months. Not all medications of the OTC list in Chapter 4 of Medicare Managed Care Manual are included.

Prosthetic devices (braces artificial limbs etc.)

Out of Network: 30% coinsurance.

In Network: 20% coinsurance for Medicare-covered medical supplies. 20% coinsurance for Medicare-covered prosthetic devices.

Renal dialysis

Out of Network: 20% coinsurance.

In Network: 20% per visit

Vision services

Out of Network: $10 copay. (Eye Exams)

Out of Network: You pay nothing. (Eye Exams)

Out of Network: You pay nothing. (Eyewear)

In Network: Contacts max of 1 every year. Glasses max of 1 every year. Routine eye exam max of 1 every year. $10 copay for Medicare-covered eye exams. Max of $100 combined benefit for this plan every year.

Preventive care

Out of Network: You pay nothing.

In Network: Annual physical exam covered. Supplemental benefits available, see carrier site for more detailed information.

Outpatient prescription drugs

Out of Network: 30% coinsurance.

In Network: 20% coinsurance for chemo drugs.20% coinsurance for prescriptions.

Tier 1 (Preferred Generic)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	$2	$4	$0
Standard Retail:	$12	$24	$5
Preferred Mail Order:	Not Offered	Not Offered	Not Offered
Standard Mail Order:	Not Offered	Not Offered	$0

Tier 2 (Generic)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	22%	22%	22%
Standard Retail:	25%	25%	25%
Preferred Mail Order:	Not Offered	Not Offered	Not Offered
Standard Mail Order:	Not Offered	Not Offered	0%

Tier 3 (Preferred Brand)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	22%	22%	22%
Standard Retail:	25%	25%	25%
Preferred Mail Order:	Not Offered	Not Offered	Not Offered
Standard Mail Order:	Not Offered	Not Offered	22%

Tier 4 (Non-Preferred Drug)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	25%	25%	25%
Standard Retail:	25%	Not Offered	25%
Preferred Mail Order:	Not Offered	Not Offered	Not Offered
Standard Mail Order:	Not Offered	Not Offered	25%

Tier 5 (Specialty Tier)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	25%	25%	25%
Standard Retail:	25%	25%	25%
Preferred Mail Order:	Not Offered	Not Offered	Not Offered
Standard Mail Order:	Not Offered	Not Offered	25%

Inpatient hospital care

Out of Network: $345 copay for days 1-5 $0 copay for days 6-90

In Network: $225 copay for days 1-5 $0 copay for days 6-90 Benefit continues for unlimited days of hospital stay.

Skilled Nursing Facility (SNF)

Out of Network: 30% coinsurance for stay

In Network: $0 copay for days 1-20 $178 copay for days 21-100

Monthly premium deductible and limits on how much you pay for covered services

$7550 in and out-of-network out of pocket maximum. $7550 in-network out of pocket maximum.

Acupuncture

Not covered

Ambulance

$225 copay

Emergency care

$90 per visit, waived if admitted within 24 hours. Maximum $90 per visit.

Hospice

You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.

Transportation

Not covered

Urgently needed services

$25 copay, waived if admitted within 24 hours.. Maximum $65 per visit.