MEDICARE ADVANTAGE / PDP

Plan Details

Clover Health

$37.50

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

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

Annual Drug Deductible: **$445.00**

ID: **H5141-39-0**

Star Rating: **3.0**

Plan Type: **Local PPO**

Part B Reduction: **No**

Effective Year: **2021**

City: **PHILADELPHIA**

State: **PA**

Zip: **19145**

Chiropractic care

Out of Network: $5 copay.

In Network: Not covered. $5 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 $2000 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: You pay nothing. (Lab Services)

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

Out of Network: 20% coinsurance. (Therapeutic Radiological Services)

Out of Network: $30 copay. (Outpatient X-Ray Services)

In Network: 20% coinsurance for other Medicare-covered therapeutic radiological services. $0-175 copay for Medicare-covered diagnostic procedures/tests. $0 copay for Medicare-covered lab services. $0-175 copay for Medicare-covered diagnostic radiological services (e.g., CT, MRI, etc). $30 copay for Medicare-covered x-rays.

Doctor's office visits

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

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

In Network: You pay nothing

Durable medical equipment (wheelchairs oxygen etc.)

Out of Network: 20% coinsurance.

In Network: 20% per item

Foot care (podiatry services)

Out of Network: You pay nothing.

In Network: You pay nothing

Hearing services

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: You pay nothing.

In Network: You pay nothing

Mental health care

Out of Network: You pay nothing.

Out of Network: $225 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: $5 copay. (Cardiac Rehabilitation Services)

Out of Network: $5 copay. (Intensive Cardiac Rehabilitation Services)

Out of Network: $5 copay. (Pulmonary Rehabilitation Services)

Out of Network: $5 copay. (Occupational Therapy Services)

Out of Network: $5 copay. (Physical Therapy and Speech-Language Pathology Services)

In Network: $5 copay for Medicare-covered cardiac rehabilitation services. $5 copay for Medicare-covered intensive cardiac rehabilitation services. $5 copay for Medicare-covered pulmonary rehabilitation services.

In Network: $5 copay for physical therapy and speech therapy. $5 copay for occupational therapy.

Outpatient substance abuse

Out of Network: You pay nothing.

In Network: You pay nothing

Outpatient surgery

Out of Network: $175 copay. (Ambulatory Surgical Center (ASC) Services)

In Network: $200 per visit

Over-the-counter items

Out of Network: You pay nothing. Plan benefit max of $125.

In Network: Max of $125 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: 20% 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

Transportation

Out of Network: You pay nothing.

In Network: Max of 10 trips to any location every year.Covered modes of transportation include medical transport, van, bus, subway, medical transport, van, bus, subway, medical transport, van, bus, subway, taxi, medical transport, van, medical transport, van, bus, subway, taxi, medical transport, van, taxi, van, van, medical transport, van, taxi, medical transport, van, taxi, taxi, taxi, medical transport, van, taxi, van, bus, subway, van, bus, subway, van, bus, subway, van, bus, subway, van, bus, subway, van, bus, subway, van, bus, subway.

Vision services

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. Max of $250 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: 20% 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:	$0	$0	$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: $225 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: $0 copay for days 1-20 $178 copay for days 21-100

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

$190 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.

Urgently needed services

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

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