

Clover

Provider Manual

2019

A guide to working better, together.

Clover

We are a Medicare Advantage company changing the way people are cared for by capturing and analyzing patient data in powerful new ways.

Our goal is to improve the quality of life for our members by offering providers like you the resources and support they need.

By establishing a close, collaborative partnership, we can share and exchange rich health data about your patients—our members. We can then start to identify conditions earlier and move closer to preventing them.

Working together, we can drive continuous improvements in patient care and help Medicare patients live longer, healthier, more fulfilling lives.

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Quick Reference Guide

cloverhealth.com/providers is the simplest, quickest way to check member eligibility and benefits, submit or check on a pre-authorization request, check the status of a claim, find other Clover providers, access documents and forms, and much more. Be sure to have your National Provider Identification (NPI) handy.

FREQUENTLY USED SERVICES	QUICK LINKS	
To submit a claim If you need to make any changes to an original claim, you can resubmit a corrected claim using one of the channels to the right.	interconnect via Change Healthcare: Payer ID#: 77023	via mail: Clover Health P.O. Box 3236 Scranton, PA 18505
To find an in-network provider	cloverhealth.com/findprovider	
To view pre-authorization criteria	cloverhealth.com/preauth	
To dispute a payment	cloverhealth.com/paymentdispute	
	via fax: 1-888-240-7243	via mail: Attn: Grievance Dept. Clover Health P.O. Box 471 Jersey City, NJ 07303
To verify patient eligibility, benefits, and copays	navinet.navimedix.com	
For all other routine forms and documents	cloverhealth.com/providerforms	

If you need additional assistance, you can call or fax using the numbers below.

DEPARTMENT	CONTACT	
Provider Services	T: 1-877-853-8019	
Care Management	T: 1-888-995-1689	
Authorization Requests (UM)	T: 1-888-995-1690	F: 1-800-308-1107
Pharmacy (CVS/Caremark®)	T: 1-855-479-3657 (PPO) T: 1-844-232-2316 (HMO)	F: 1-855-633-7673
Appeals and Grievances	T: 1-888-657-1207	F: 1-732-412-9706 (Appeals) F: 1-551-227-3962 (Grievances)
Member Services	T: 1-888-778-1478	

Legal Overview

Except where otherwise indicated, this Provider Manual is effective as of January 1, 2019 for providers currently participating in the Clover network.

This Provider Manual will serve as a resource for navigating Clover's operations and processes. In the event of a conflict or inconsistency between this Provider Manual and the express provisions of your Provider Agreement with Clover, including any regulatory requirements appendices attached to it, the provisions of your Provider Agreement will prevail. We reserve the right to periodically update this Provider Manual.

Clover Members

We believe that doctors care best for their patients when their time together is efficient and productive. This section outlines the benefits, rights, and responsibilities of Clover members, and shows you how to verify member eligibility.

IDENTIFICATION OF CLOVER MEMBERS AND ELIGIBILITY

You (or your office staff) are responsible for verifying the eligibility of each member before rendering non-emergency services or treatment. Clover issues identification cards that you can use to verify member eligibility. When a Clover member arrives in your office, you should confirm the member's eligibility by:

- Calling Provider Services at **1-877-853-8019**, or
- Logging on to NaviNet at navinet.navimedix.com (where applicable), selecting Clover Health, and entering the member ID from the Clover ID card.

Clover identification cards contain the following information:

- Member plan name (e.g., Clover Health Choice PPO or Clover Health Classic HMO)
- Member first and last name
- Member ID
- Plan ID

A sample of the ID card can be found in the [Appendix](#).

Some Clover members have additional insurance coverage, like Medicaid. Clover members who have dual eligibility should present identification cards for each of their coverages, including any Medicaid benefits that might be administered by another payer. Additional coverage can pay for costs that are not covered by the Clover plan as long as all services and items are covered by each plan. Members should refer to the Evidence of Coverage documents for both their Clover plan and their other insurance to learn what's covered by each plan.

NAVINET

Clover partners with NaviNet to give you fast, secure, HIPAA-compliant access to provider and member information. To confirm member eligibility:

Online

- Log on to NaviNet at navinet.navimedix.com (where applicable)
- Select Clover Health
- Enter the number from the member's Clover ID card

Phone

- Call Provider Services at **1-877-853-8019**. We're available 8 am–5:30 pm local time, Monday–Friday, to assist you.

COVERED SERVICES

Clover offers PPO plans in select counties of New Jersey, Texas, Georgia, Pennsylvania, South Carolina, Tennessee, and Arizona and HMO plans in select counties of New Jersey and Texas.

Our PPO plans don't require a referral by a PCP to access care, but we anticipate that the providers our members trust for their primary care will help them understand how to access care within our network to maximize their plan benefits.

Our HMO plans also don't require a referral, but access to care is limited to providers who are in-network or contracted with Clover, except for services outlined in [Chapter 4](#) of the Medicare Managed Care Manual.

Clover members enjoy a comprehensive benefit package, including the primary, preventive, and specialty care necessary for good health. Covered services must be medically necessary and appropriate. We do not pay claims for services excluded from the Medicare program. You can learn more about Medicare excluded services [here](#). To obtain member benefit information:

Online

- Log on to www.cloverhealth.com/en/members/plan-documents/plan-details.
- Click the applicable benefit year.
- Select the applicable ZIP code.
- Click **See plan details** and then select a plan you would like to obtain more information about.

Phone

- Call Provider Services at **1-877-853-8019**. We're available 8 am–5:30 pm local time, Monday–Friday, to assist you.

A member who elects to receive medical care for services not included in the contract, or for services that are determined by Clover to not be medically necessary, will be responsible for payment. In those instances, direct the member to the EOC and document prior approval from the member for such out-of-pocket expenses, or [submit an organizational determination](#). All services can be subject to applicable member share-of-cost.

COORDINATION OF BENEFITS (COB)

Coordination of benefits (COB) and services is intended to avoid duplication of benefits and at the same time preserve certain rights to coverage under all plans in which the member is covered. COB is an important part of Clover's overall objective of providing healthcare to members on a cost-effective basis. Clover members cannot be billed for covered services rendered except for any copays for which the member can be responsible. Clover members who have Medicaid QMB (Qualified Medicaid Beneficiary) program as other coverage are not responsible for copay. Your contract with Clover requires you to accept Clover's payment as payment in full.

DEFINITIONS

Primary plan: Determines a member's health benefits without taking into consideration the existence of any other plan.

Secondary plan: Can pay the remaining costs after the primary plan has paid, for services or items covered by both payers. All Clover members must follow these procedures:

- All Clover members will be responsible for paying copays at the time of their office visit. If the member has additional coverage (like Medicaid), that coverage can reduce or eliminate the amount owed if the service rendered is billable to the other payer.
- If Clover is the secondary insurance, attach the explanation of benefits from the primary carrier and send the claim to Clover for consideration of the remaining balance.
- Under no circumstances can members be directly billed beyond the amount due for their cost-share.

Coordination of benefits for Medicare Advantage members with Medicaid

Clover members who have limited income and resources can receive help paying out-of-pocket medical expenses from Medicaid. If a member is identified as having secondary insurance coverage through Medicaid, you should obtain a copy of the member's Medicaid card, and/or the card for the plan that administers the benefit to bill Medicaid after receiving the EOP from Clover.

No share of cost should be collected at the time of the visit from a member with Medicaid coverage. For further information, your office can contact Provider Services at **1-877-853-8019**. We're available 8 am–5:30 pm local time, Monday–Friday, to assist you. Or, you can contact the number listed on the member's Medicaid card.

Coordination of benefits for Medicare Advantage members with multiple payer sources

If a member has coverage from more than one payer or source, we coordinate benefits with the other payer(s) in accordance with the provisions of the member's benefits. If you have knowledge of alternative primary payer(s), you must bill the other payer(s) with the primary liability based on such information prior to submitting claims for the same services to Clover.

You are also expected to provide us with relevant information you have collected from members regarding coordination of benefits and to bill payer(s) with the primary liability based on such information prior to submitting bills for the same services to Clover. To the extent permitted by law, if Clover is not the primary payer, your compensation by Clover will be the difference between the amount paid by the primary payer(s) and your applicable rate, less any applicable copays or coinsurance.

Because members accept Clover benefits by their participation in the COB program, they are legally responsible to adhere to the rules and regulations required of all Clover members, such as use of the PCP and/or prior approval for out-of-plan services.

Clover cannot deny a claim, in whole or in part, on the basis of "coordination of benefits," unless we have a reasonable basis to believe that the member has other insurance coverage that is primary for the claimed benefit. In addition, if we request information from the member regarding other coverage and do not receive

the information within 45 days, we must adjudicate the claim. However, the claim cannot be denied on the basis of nonreceipt of information about other coverage.

SUBROGATION

In the event that there is a third party responsible for the cause of a member's injury or illness, Clover reserves the right to recover benefits previously paid to a provider for related healthcare services. Recoveries can be pursued by Clover or its contracted vendors to the extent permitted under applicable law.

EXTRA BENEFITS AND SERVICES

Most Clover plans offer the following supplemental benefits and extra services that are not covered by Original Medicare.

Supplemental preventive dental

Most Clover plans provide coverage for the following dental services through [DentaQuest](#):

- Two oral exams per year, \$0 copayment
- Two cleanings per year, \$0 copayment
- One dental X-ray per year, \$0 copayment

Dental claim submission

DentaQuest requires providers to submit claims on the member's behalf; claims that are received directly from the member will not be processed.

Dental claims can be sent to DentaQuest online, by fax, or by mail. Claims must be submitted on ADA-approved claim forms (2006 or newer).

- **Online:** [Click here for more information.](#)
- **Fax:** 1-262-834-3589
- **Mail:** Dental claims can be sent to the following address or the fax number above. Claims must be submitted on ADA-approved claim forms (2006 or newer):

DentaQuest
PO Box 2906
Milwaukee, WI 53201-2906

Coverage for procedures normally offered by a physician in a hospital, and that involve the conditions listed below, are not covered through DentaQuest and should be billed under Part B. Refer to the [Claims and Billing section](#) of this manual for more information about Part B claims submission.

- Conditions involving the jaw or related structures
- Setting fractures of the jaw or facial bones
- Extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease and other related services

Dental care that is not covered includes routine dental care procedures that are performed after the underlying health condition was treated, such as:

- Tooth removal due to facial injury from a car accident
- Any dental care related to the car accident that can arise at a later time
- Some dental-related hospitalizations; for example, we can cover treatment for a member who develops an infection after having a tooth extraction or requires observation during a dental procedure because of a health-threatening condition

If you have questions or concerns, please call DentaQuest's Dental Provider Services at:

- **New Jersey:** 1-855-398-8409
- **Georgia:** 1-800-516-0124
- **Pennsylvania:** 1-855-343-7401
- **Texas:** 1-888-308-9345
- **Tennessee:** 1-888-554-5542
- **Arizona:** 1-800-440-3408
- **South Carolina:** 1-800-685-2371

Supplemental dental benefits are subject to the same [appeals process](#) as any other benefits.

Supplemental vision

Most Clover plans offer routine vision exams and eyewear through our partner, [EyeQuest](#).

Supplemental vision benefits include:

- One routine vision exam per year, \$0 copayment
- Up to a \$100 allowance per year for routine eyewear (including lenses, frames, or contacts), \$0 copayment
- Includes lenses, frames, or contacts

Supplemental vision benefits are subject to the same [appeals process](#) as any other benefits.

Vision claim submission

Vision claims can be sent to [EyeQuest](#) electronically, by fax, or by mail.

- **Online:** [Click here for more information.](#)
- **Fax:** 1-888-696-9552
- **Mail:** Vision claims can be sent to the following address or fax the number above. Be sure to include a copy of the member's Clover Health ID:
EyeQuest
Attn: Vision Claims Processing
PO Box 433
Milwaukee, WI 53201-0433

If you have questions or concerns, please call EyeQuest's Vision Provider Services at:

- **New Jersey:** 1-844-824-2014
- **Georgia:** 1-844-824-2014
- **Pennsylvania:** 1-844-824-2014
- **Texas:** 1-844-824-2014
- **Tennessee:** 1-844-824-2014
- **Arizona:** 1-844-824-2014
- **South Carolina:** 1-844-824-2014

Supplemental hearing

Most Clover plans include a routine hearing exam, as well as access to state-of-the-art hearing aids through [TruHearing](#). Supplemental hearing benefit includes:

- One routine hearing exam per year, \$0 copayment
- Two TruHearing hearing aids, one per ear, per year:
 - **Advanced aid**, \$699 copayment for each hearing aid, or
 - **Premium aid**, \$999 copay for each hearing aid

TruHearing hearing aid purchase includes:

- Three TruHearing provider visits for evaluation and fitting within the first year of the hearing aid purchase
- 45-day trial period and 3-year extended warranty
- 48 batteries per aid (for non-rechargeable hearing aid models)

If you have questions or concerns, please call TruHearing Provider Relations at **1-866-581-9462**.

To use the TruHearing benefit, members must call TruHearing at **1-855-205-5574**.

Gym/fitness

Each Clover member will receive one [SilverSneakers®](#) membership at a participating fitness center.

Members who misplaced their SilverSneakers ID card can request a new card by calling SilverSneakers Customer Service at **1-888-423-4632**, Monday–Friday, from 8 am to 8 pm EST.

Over-the-counter (OTC)

Some Clover plans include a quarterly allowance that can be used to pay for select over-the-counter medications and supplies. If a plan includes this benefit, members can refer to their Evidence of Coverage (EOC) to find their quarterly allowance and benefit limitations.

Starting January 1, 2019, members can order OTC items online at clover.otchs.com or by calling 1-888-628-2770 (TTY 1-888-672-2688) Monday–Friday, from 9 am to 8 pm EST. For more information, benefit limitations, and a complete list of covered items, see the [2019 OTC Health Solutions Item Catalog](#).

Covered plans and their quarterly allowances:

- GA Clover Health Choice PPO (026): **\$40**
- TN Clover Health Choice Value PPO (034): **\$30**
- TX Clover Health Choice Value PPO (035): **\$25**
- SC Clover Health Choice PPO (036): **\$50**
- SC Clover Health Choice Value PPO (037): **\$85**
- PA Clover Health Choice Value PPO (039): **\$30**
- NJ Clover Health Choice PPO (041): **\$25**
- NJ Clover Health Choice Value PPO (042): **\$50**
- TX Clover Health Classic HMO (005): **\$40**

Teladoc

Clover plans include 24/7 access to Teladoc, a phone consultation service with mental health professionals and board-certified doctors. For more information, call **1-800-835-2362** or visit teladoc.com

MEMBERS' RIGHTS AND RESPONSIBILITIES

We ensure the following rights and responsibilities for our members.

Members' rights

- Protection and privacy of personal health information
- Timely access to covered services and drugs
- Clear, simple presentation of health-related information
- Fair and respectful treatment
- Opportunity to make complaints and ask that we reconsider decisions we have made
- Opportunity to make their own decisions about their care
- Opportunity to ask for reconsideration about claims payment
- To be provided with information about the plan, its network of provider's, and covered services

Members' responsibilities

- Familiarity with covered services and the rules required to receive them
- Full disclosure of plans enrolled in, and of changes in health status, geography, and other pertinent health-related personal information
- Full and/or timely payments toward any and all amounts owed
- Understanding of their health problems and participation in developing treatment goals mutually agreed upon with their healthcare providers

Members can contact Customer Experience for help or with questions or concerns. For additional details on members' rights and responsibilities, refer to the Clover 2019 [Evidence of Coverage](#) booklet or call Customer Experience at **1-888-778-1478 (TTY 711)**. We're available 8 am–8 pm local time, 7 days a week to assist you. Alternate technologies (for example, voicemail) will be used on the weekends, holidays, and from April 1st through September 30.

MEMBERS' PRIVACY RIGHTS

Members have the following privacy rights:

- To see any and all information in their medical records
- To know when their medical records have been shared
- To receive a copy of their medical records
- To ask for additions or corrections to their medical records

CULTURAL COMPETENCY

To help integrate cultures of diverse backgrounds within Clover and across the organizations we partner with, we follow Culturally and Linguistically Appropriate Service (CLAS) standards—a collective set of linguistic services, mandates, guidelines, and recommendations issued by the United States Department of Health and Human Services Office of Minority Health.

Learn more at thinkculturalhealth.hhs.gov.

ADVANCE DIRECTIVES

In the event members become incapacitated and/or unable to communicate their needs, we follow the instructions as outlined in the members' advance directives if they have any. Examples of advance directives include a living will, durable power of attorney for healthcare, healthcare proxy, or do not resuscitate (DNR) request.

Under advance directive guidelines, we defer to you to honor member requests. You should discuss advance directives with your patients (as appropriate) and file a copy of any advance directive document in the medical record. Each medical record that contains an advance directive should clearly indicate that such document is included.

You can find more information on advance directives on your State Department of Health website:

New Jersey: nj.gov/health/advancedirective

Pennsylvania: <http://www.aging.pa.gov/aging-services/caregiver-support/Pages/Caregivers-of-Adults.aspx>

Texas: <https://hhs.texas.gov/laws-regulations/forms/advance-directives>

Georgia: http://www.fcs.uga.edu/docs/Georgia_Advance_Directive_for_Healthcare_Form.doc

South Carolina: <https://aging.sc.gov/>

Tennessee: <https://www.tn.gov/aging.html>

Arizona: <https://www.azag.gov/seniors/life-care-planning>

Provider Responsibilities

Clear and transparent communication is integral to the success of our partnership. We will strive to explicitly articulate our provider expectations and share how we can be a valuable resource for you.

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STANDARDS OF PARTICIPATION

We update our provider information frequently. Please let us know when any of the following information about your practice changes:

- Status
- Demographic or location
- Payment or credentialing information
- Tax identification number
- Office or billing entity location(s)
- National Provider Identifier(s)
- Any other relevant provider information

Acceptance of new patients

If you decide not to accept new patients or additional Clover members, please give us 60 days' notice. You can submit updates in the following ways:

- Go to <https://www.cloverhealth.com/en/providers/provider-tools> and click on the **Update your information** button in the Provider Resources section to submit an update request
- Email provider-data@cloverhealth.com

Privileges

Clover reserves the right to require admission privileges with its in-network providers. If you or any of your group practice providers lose privileges at any hospital, please notify us no later than 10 business days following the date of the termination of privilege.

APPOINTMENTS AND ACCESS STANDARDS

We are dedicated to arranging quality access to care for our members. To help with this process, we ask that you and your office staff adhere to the following recommendations:

- **Telephone coverage after hours:** An answering service or a telephone recording that directs a member to call another telephone number or 911 in the event of an urgent or emergent situation.
- **Telephone access during normal business hours:** Immediate responses to any urgent or emergency health events, within 4 hours for non-urgent calls, and within 1–2 business days for routine calls.
- **Covering provider:** When you are on extended leave (vacation, illness, etc.) you must arrange with another participating primary care provider or specialist to provide accessible 24-hour coverage. Coverage must extend beyond 911, except in the event of an emergency or urgent situation.
- **Appointments:** You must make every effort to see a member within the following time frames:
 - **Emergent:** Immediately; member should be directed to call 911 in the event of an emergency or go to the emergency room for treatment
 - **Urgent:** Within 24 hours

- **Routine/Symptomatic:** Within 7 days
- **Wellness/Nonsymptomatic:** Within 30 days
- **Office waiting time:** Should not exceed 30 minutes from the time of the scheduled appointment.
- **Minimum office hours:** You must practice for a minimum of 16 hours a week and must promptly notify Health Plan of changes in your office hours and locations as soon as this information becomes available, but no later than 3 business days after the change takes effect. The minimum office hour requirement can be reduced under certain circumstances for good cause, with Health Plan's prior written approval.
- **Accessibility:** You are expected to meet the federal and state accessibility standards and those defined in the Americans with Disabilities Act of 1990. Healthcare services provided through Clover must be accessible to all members.

Clover tracks and evaluates issues relating to waiting times for appointments, appropriateness of referrals, and other indications of capacity.

Refer to your specific **Provider Agreement** for additional details.

ACCESS TO MEDICAL RECORDS

Clinical documentation of disease burden is central to collaborative management and is the cornerstone to care. As needed, Clover will request medical records to ensure an accurate representation of patients' clinical disease and needs. Medical records can also be requested for audits, quality assurance purposes, as well as to ensure proper billing and claims payment practices.

MEDICAL RECORD STANDARDS

We believe that updated, complete documentation is an essential component to the delivery of quality medical care and collaboration. We reserve the following rights to ensure our member profiles are comprehensive.

Access and confidentiality

We reserve the right to inspect (at reasonable times) any and all records, specifically any medical records you maintain pertaining to members. This includes, but is not limited to, assessing quality of care, collecting data for Healthcare Effectiveness Data and Information Set (HEDIS®) reporting, collecting data for risk adjustment reporting, coordinating medical care evaluations and audits, determining on a concurrent basis the medical necessity and appropriateness of any care being provided, and ensuring proper billing and claims payment. Federal and state regulatory bodies can determine other purposes for having access to members' medical records.

For information on member rights as they relate to the above, refer to the Members' Privacy Rights section of this Provider Manual.

Medical record documentation

- Medical information must be legible and follow a logical and consistent format, with page numbers indicated (e.g., “Page 1 of 2”) if an encounter spans multiple pages.
- The record must contain complete encounter information for each encounter in the chart.
This includes:
 - Member’s full name and date of birth
 - Provider’s full name and title
 - Facility name
 - Date(s) of service
 - Documentation of all services provided by the physician as well as other nonphysician services (e.g., physical therapy, diagnostic or laboratory services, home healthcare)
- The record must indicate:
 - All illnesses and medical conditions
 - Medications list
 - Consultations/referrals
 - Present issue
 - Treatment plan
 - Follow-up plan
 - Preventive screenings and health education offered
 - Documentation on advance directives
- Information should be stored within a secure folder in a safe place.
- No record should be altered, falsified, or destroyed. If a correction is introduced, the individual correcting the record should draw a single line through the item to be corrected, and date and initial the correction.
- All telephone messages and consult discussions must be clearly identified and recorded.
- The medical record system should provide a mechanism to ensure member confidentiality.

Electronic medical record integrations

Clover partners directly with electronic medical record (EMR) and integration vendors to automate the transmission of member charts via a secure and HIPAA-compliant connection.

Integrations automate the transmission of member charts to Clover without any additional effort or disruption to your practice. Under no circumstances does Clover have access to patient data for non-Clover members as a result of this integration. Benefits of participating in a Clover EMR integration include:

- Enhanced care coordination with Clover through incorporation of EMR data into Clover’s advanced analytics platform
- Giving time back to your office staff that would have otherwise been spent responding to traditional medical record requests
- Reduced waste and environmental impact of printing charts, made possible through a paperless medical record retrieval
- Automated identification and transmission of member charts to Clover

Although we encourage participating providers to use EMR to help streamline your administrative processes, help protect your patients' information, and result in faster processing, Clover will also accept paper chart submissions and can occasionally request a paper chart to verify the accuracy of EMR data.

NON-ADHERENT CLOVER MEMBERS

We recognize that you may need help in managing non-adherent members. If you have an issue with a member regarding behavior or treatment cooperation and/or completion, or if you have a member who cancels or does not appear for necessary appointments and fails to reschedule, even after follow-up attempts by you and/or your office, contact Provider Services at **1-877-853-8019**. We're available 8 am–5:30 pm local time, Monday–Friday, to assist you.

MEDICARE RISK ADJUSTMENT PROCESS

We understand that meeting members' medical needs is the first step to improving their health. Accurately defining members' risk levels allows us to better meet patients' needs and manage their care. In light of this, we use standard Centers for Medicare and Medicaid Services (CMS) Medicare guidelines to measure our members' health relative to their peers using a risk adjustment model that considers their demographic and diagnoses. We then use these measures to assess healthcare utilization needs and cost, allowing both you and payers to organize around these needs.

PROVIDER DATA COLLECTION

Initial roster and facility data collection

Clover requires a fully completed and up-to-date roster and facility data in order to load practitioners, groups, and facilities into our internal systems and Provider Directory. Any refusal to provide accurate and up-to-date provider data to Clover Health can result in the withholding of payment for services provided to Clover Health members.

Directory validation

Clover conducts outreach to every provider in the Provider Directory to validate demographic and contact information. Outreach is performed on a quarterly basis by email or by phone.

For health systems and large groups, Clover will request the organization's provider roster by email or phone on a quarterly basis. The organization is responsible for the accuracy of the information sent to Clover and any inaccurate data discovered by Clover will be quickly communicated back to the provider for verification.

Additions, changes, and terminations should be reported to Clover promptly so internal systems and the Provider Directory remain current.

Any refusal to share updated provider data with Clover can result in the withholding of payment to the provider for services provided to Clover members.

Updating provider information

You can submit updates to provider information, such as a Tax ID or practice location address, in the following ways:

- Go to <https://www.cloverhealth.com/en/providers/provider-tools> and click on the **Submit a Provider Data Update** button to submit an update request
- Email provider-data@cloverhealth.com

If you have questions or require assistance, you can contact Provider Services at **1-877-853-8019**. We're available 8 am–5:30 pm local time, Monday–Friday, to assist you.

COMPLIANCE WITH FEDERAL LAWS AND NONDISCRIMINATION

The Code of Federal Regulations (42 CFR 422.504) requires that Medicare Advantage Organizations have oversight for contractors, subcontractors, and other entities. The intent of these regulations is to ensure services provided by these parties meet contractual obligations, laws, regulations, and CMS instructions. Clover is held responsible for the compliance of its providers and subcontractors with all contractual, legal, regulatory, and operational obligations.

Clover does not discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. Payments received by contracted providers from Medicare Advantage plans for services rendered to plan members include federal funds; therefore you, as a contracted provider, are subject to all laws applicable to recipients of federal funds, including but not limited to: Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, and all other laws that apply to organizations that receive federal funding.

Claims and Billing

We know that you prefer to spend your time with patients, so we do what we can to make it easier to manage billing and paperwork. This section describes our claims process, and how we can work together to ensure you're paid accurately and on time.

CLAIMS SUBMISSION

Electronic submission

We encourage participating providers to use electronic claim submissions whenever possible. Doing so can help streamline your administrative processes, help protect your patients' information, and result in faster claim processing and payment. Clover supports electronic submission via the HIPAA transaction set (837P and 837I) and upholds Medicare guidance requiring electronic claim submission as defined by the American Simplification Compliance Act.

You should submit claims via **Change Healthcare** with Clover's Payer ID #77023.

Paper submission

Clover also accepts the [CMS-1500](#) and the [CMS-1450](#) paper claim forms.

Paper claims must be submitted to:

Clover Insurance
PO Box 3236
Scranton, PA 18505

Timely filing of claims

You should refer to your Provider Agreement for filing guidelines and documentation requirements. Unless otherwise specified in your Provider Agreement, Clover's standard timely filing limit is 90 days from the claim date of service for in-network providers. As set forth in your Provider Agreement, you cannot bill members for services submitted beyond the timely filing limit. Corrected claims must also be submitted within our timely filing requirements.

Claims processing

We use a combination of guidelines established by CMS and internal claims processing policies to assist in determining proper coding. These guidelines and policies dictate claims edits, adjustments to payment, and/or a request for review of medical records that relate to the claim.

You can refer to one of the following CMS guidance documents on electronic and paper claim submissions:

[Medicare Billing: 837P and Form CMS-1500](#)

[Medicare Billing: 837I and Form CMS-1450](#)

You can check the status of claims you've submitted:

Online

Log on to NaviNet at navinet.navimedix.com; or

Phone

Call Provider Services at **1-877-853-8019**. We're available 8 am–5:30 pm local time, Monday–Friday, to assist you.

Clean claims

Clover uses the [CMS Medicare Advantage definition of a clean claim](#), which consists of a properly completed claim that can be processed as soon as it is received.

Clean claims include:

- Complete coding
- Provider information
- Itemization
- Date of service
- Billed amounts
- Substantiating documentation needed to meet the requirements of an encounter with a member

Failure to submit a clean claim can result in a delay of payment and/or rejection of a claim. Common types of errors include incomplete fields, invalid codes, lack of supporting medical records, provider data mismatches, and use of the wrong claim form(s).

Timely processing of claims

Clover is required to uphold standard claims timeliness guidelines, which either are stipulated in your Provider Agreement or follow [CMS timeliness requirements](#).

Refer to the [CMS guidelines](#) for more information.

Claims payment

You will be reimbursed according to the compensation provisions of the Compensation Schedule included in your Provider Agreement.

Sequestration

At Clover, we use the same sequestration reductions as those imposed by the Centers for Medicare and Medicaid Services (CMS). All providers are reimbursed using a fee schedule based on the Medicare payment system, percentage of Medicare Advantage premium or Medicare-allowed amount (e.g., resource-based relative value scale [RBRVS], diagnosis-related group [DRG], etc.) and will have the 2% sequestration reduction applied the same way it would be applied by CMS. This reduction applies to all Medicare Advantage plans.

The amount of the sequestration reduction for each affected claim will be identified as “Sequestration” on the Remittance Advice document that providers will receive from Clover.

Claim corrections

We will deny a claim if it is determined to be incorrect or incomplete due to missing or invalid information. In this event, you can resubmit a corrected claim within the timely filing period. Unless otherwise specified in your Provider Agreement, Clover’s standard timely filing limit is 90 days from the claim date of service for in-network providers. As set forth in your Provider Agreement, you cannot bill members for services submitted beyond the timely filing limit. As stated above, corrected claims must be submitted within our timely filing requirements.

Correcting or Voiding Electronic Claims

- **Professional claims (837p):** Enter Frequency Code 7 for corrections, or Frequency code 8 to void, in Loop 2300 Segment CLM05-3. Enter the original claim number on the 2300 loop in the REF*F8*.
- **Institutional claims (837i):** Submit with the last character of the Type of Bill as 7, to indicate Frequency Code 7 for corrections, or Type of Bill as 8, to indicate Frequency Code 8 to void.

Correcting or Voiding Paper Claims

- **Professional claims CMS-1500:** Stamp “Corrected Billing” on the CMS 1500 form. Complete box 22 when resubmitting a claim. Enter the appropriate bill frequency code left-justified in the left-hand side of the field:
 - 6 - Corrected Claim
 - 7 - Replacement of prior claim
 - 8 - Void/Cancel prior claim
- **Institutional claims UB-04:** Submit with the last digit of 7 in the Type of Bill for corrections, or last digit of 8 for void claims.

Corrected claims should be submitted with all line items completed for that specific claim, and should not be filed with just the line items that need to be corrected. Please share this information with your practice management software vendor, as well as your billing service or clearinghouse, if applicable.

The following CMS guidance can help you to determine what information to include on claim submissions:

- [Physician and nonphysician practitioner services](#)
- [National Correct Coding Initiative](#)
- [CMS Fee Schedule Administration and Coding Requirements](#)
- [Medicare Administrative Contract \(MAC\)—Jurisdiction H \(Texas\)](#)
- [Medicare Administrative Contract \(MAC\)—Jurisdiction L \(New Jersey\)](#)
- [Physician Fee Schedule \(Georgia\)](#)
- [CMS Transmittals](#)
- [DME Fee Schedule—Jurisdiction A \(New Jersey\)](#)
- [DME Fee Schedule \(Texas\)](#)
- [Items and Services Not Covered Under Medicare](#)

READMISSIONS REVIEW PROGRAM

Clover reviews the following as part of the Readmissions Review Program:

- Same-day readmission for a related condition
- Same-day readmission for an unrelated condition
- Planned readmission/leave of absence
- Unplanned readmission less than 30 days after the prior discharge

If a patient is readmitted to a facility on the same day as a prior discharge for the same or a related condition, CMS and Clover require the facility to combine the two admissions on one claim. Clover will deny both the initial and subsequent admissions for payment as separate DRGs. The facility must submit both admissions combined on a single claim to receive reimbursement. For a same-day readmission to qualify for separate reimbursement, the medical record must support that the conditions are clinically unrelated. Consistent with CMS billing requirements, if a patient is readmitted during the same day for an unrelated condition, two properly coded claims must be submitted to Clover.

If a patient is readmitted to a facility as part of a planned readmission or leave of absence, the admissions are not considered two separate admissions. Clover requires the facility to submit one claim and receive one combined DRG payment for both admissions because they are for the treatment of the same episode.

Reimbursement for readmissions may be denied (see [Medicare QIO Manual](#), Chapter 4, Section 4240) if the readmission:

- Was medically unnecessary
- Resulted from a premature discharge from the same hospital
- Was a result of circumvention of the PPS by the same hospital

For a complete description of the program, visit cloverhealth.com/providers.

Program integrity

Accurate payment is important to us at Clover. We strive to ensure that the care you provide to our members is effectively administered and fairly paid—by the responsible party, for eligible members, according to contractual terms, not in error or duplicate, and free of wasteful or abusive practices. To ensure that claims payments are issued in accordance with CMS guidelines, the integrity of our payment programs is overseen by dedicated staff and can include the use of contracted vendors. All claims can be subject to prospective, concurrent, or retrospective review for both billing and payment accuracy.

Overpayment recovery

We abide by [CMS guidelines for overpayment recoupments](#), including: provider notification, opportunity for rebuttal, and the possibility of automatic recoupments from future claims payments. Clover can reopen and revise its initial determination or redetermination on a claim on its own motion:

- Within 1 year from the date of the initial determination or redetermination for any reason; or
- Within 4 years from the date of the initial determination or redetermination for good cause as defined in CMS Medicare Handbook §10.11; or
- At any time if:
 - There exists reliable evidence that the initial determination was procured by fraud or similar fault as defined in the Code of Federal Regulations (42 CFR §405.902); or
 - The initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based. Third party payer error does not constitute clerical error or similar fault as defined in the [Code of Federal Regulation § 405.986 Good cause for reopening](#).

We will provide written documentation that identifies affected claims and justifies the reimbursement request. Overpayments can stem from coding edits, improper coordination of benefits, technical denials, and medical necessity review among other reasoning outlined by applicable law. Clover will not, however, base a reimbursement request for a particular claim on extrapolation of other claims, except where applicable law permits, including any of the following circumstances:

- In judicial or quasi-judicial proceedings, including arbitration
- In administrative proceedings
- Where relevant records you were required to maintain have been improperly altered or reconstructed, a material number of the relevant records are otherwise unavailable
- Where there is clear evidence of fraud by you, and Clover has investigated the claim in accordance with its fraud prevention plan

Clover can collect a monetary penalty against a reimbursement request including, but not limited to, an interest charge.

Except as expressly otherwise stated in the Provider Agreement, Clover attempts to collect overpayments according to the following guidelines:

- Clover generally initiates recoupments 41 days after the date of our refund request letter if no refund check or written dispute is received.
- If you submit a written dispute to us, we will not initiate recoupment activity (or will cease recoupment activity) to the extent administratively feasible while the dispute is under review.
- If we uphold our original determination, we will provide written notification. We will also retain any recoupments already processed and/or proceed with recoupments previously put on hold.
- If we overturn our original determination, we will provide written notification. We will also repay any recoupments already processed and/or permanently remove claims from the recoupment process.

When refunding an overpayment by check, be sure to include all appropriate information to help us identify the overpaid claim:

- Member name and Clover ID
- Date of service
- Billed and paid amounts
- Provider remittance advice that you received for the claim and/or the refund request letter you received from Clover or one of our contracted vendors

Overpayment refund checks can be sent to:

Clover
ATTN: Program Integrity
PO Box 471
Jersey City, NJ 07303

If we determine upon investigation that our overpayment was a result of fraud you have committed, we will report the fraud to the Office of the Insurance Fraud Prosecutor as required by law. We can then take action to collect an overpayment by assessing it against payment of any future claim submitted by you.

Fraud, Waste, and Abuse

We trust that our providers will work ethically to deliver the highest-quality medical care and abide by the proper administrative guidelines. In the rare event that a provider compromises this integrity, we support the laws put in place to combat fraud, waste, and abuse.

STATE AND FEDERAL LAWS

Clover recognizes the importance of preventing, detecting, and investigating fraud, waste, and abuse (FWA), and is committed to protecting and preserving the integrity and availability of healthcare resources for members. Clover must ensure that First Tier, Downstream, or Related Entities (FDR) receive general compliance training, as well as fraud, waste, and abuse training.

Federal and state fraud and abuse laws that apply to you include the False Claims Act, the Anti-Kickback Statute, and the physician self-referral law (Stark Law). Violations of these laws can result in nonpayment of claims, civil monetary penalties (CMP), exclusion from all federal healthcare programs, and criminal and civil liability.

CLOVER'S FRAUD WASTE AND ABUSE OBLIGATIONS

As a partner of CMS, we are obligated to monitor for signs of fraud, waste, and abuse; and to ensure well-managed care through a payment integrity review both before and after payment is issued. Clover uses software tools to identify providers and facilities whose billing practices match patterns associated with suspicious conduct.

If a claim, provider, or facility is identified as a behavioral outlier, further investigation is conducted by Clover to determine the reason(s) for the outlier behavior or approximate explanation for an unusual claim, billing, or coding practice. If the investigation results in a determination that the provider's or facility's actions can involve fraud, waste, or abuse, the provider or facility is notified and given an opportunity to respond, and Clover can institute an overpayment recovery process as described above.

These claim types, providers, or facilities can be placed under prepayment review and be subject to one or more clinical utilization management guidelines. The impacted providers and/or facilities are notified of a request for additional clinical information in support of the medical necessity of services billed and coded on the identified claims in prepayment review.

Reporting fraud, waste, and abuse

If you think you are in a problematic relationship or have been following billing practices and you realize you were wrong:

1. Immediately cease filing the problematic bills.
2. Seek knowledgeable legal counsel.
3. Determine what money you collected in error and report and return overpayments.
4. Undo the problematic association by taking all steps to free yourself.
5. Consider using the OIG or CMS self-disclosure protocols.

To report suspicious activity, contact:

OIG Fraud Hotline:
1-800-HHS-TIPS (1-800-447-8477)
TTY 1-800-377-4950
<https://oig.hhs.gov/fraud/report-fraud/>

You can also report suspicious activity by calling Clover's Compliance and Ethics Hotline at **1-877-284-6962** or by email at compliance@cloverhealth.com.

Compliance training

CMS requires Medicare Advantage (MA) organizations and Part D plan sponsors, including Clover, to annually communicate specific compliance requirements, and FWA requirements to their "first tier, downstream, and related entities" (FDRs), which include contracted physicians, healthcare professionals, facilities, and ancillary providers, as well as delegates, contractors, and related parties. This training may be completed by accessing the General Compliance Training available on the CMS Medicare Learning Network® at cms.gov. You can download this training material and add information specific to your organization but you cannot alter the CMS training material. This training must be completed annually. You must retain a record (e.g., training materials, sign-in sheets of the completed training, etc.) for 10 years.

Access to medical records

Medical records access is central to our assessment of payment integrity and the evaluation of medical necessity. In the processing of claims, if more clinical data is required, our team or a trusted third-party requests medical records and pends the processing of the claim until the records are received and evaluated.

MEMBER COST-SHARE

As a provider, you play a critical role in our network and in the provision of healthcare services to our members. In accordance with CMS regulations and as included in your Provider Agreement, you can only bill or collect payments for applicable copays, coinsurance, or deductibles. You cannot bill members directly or request additional payment from our members beyond the cost-share stipulated in the member's plan for covered services rendered.

Clover encourages you to collect all applicable copays at the time services are rendered but to defer the collection of coinsurance and outstanding deductibles until Clover has processed the claim and an explanation of payment (EOP) has been received. The primary care physician and emergency room copays are printed on the member's Clover ID card; alternatively, all member copays can be obtained:

Online

Log on to [NaviNet](#).

Phone

Call Provider Services at **1-877-853-8019**. We're available 8 am–5:30 pm local time, Monday–Friday, to assist you.

If the amount you collect from a member exceeds that member's payment responsibility, you must reimburse the excess amount to the member within 60 days or by the time frame that is specified in your Provider Agreement with Clover. To determine the member's responsibility, refer to the EOP. If a correction to a claim or a payment must be made, the result of which indicates that the original amount collected in member cost-share exceeds the member's actual responsibility, it is your responsibility to reimburse the excess amount to the member. Furthermore, you must advise members of any charges that will accrue that are not covered by Clover and obtain prior approval from the member before requesting payment for such out-of-pocket expenses.

Balance billing and inappropriate billing of members

Inappropriate billing of members includes billing members for services where payment from Clover has not been obtained due to claim cleanliness issues or other billing issues.

If you are a Medicare-participating provider or you contract with Clover, you cannot balance bill or inappropriately bill members. Any such billing is a violation of the Provider Agreement and applicable state laws. Providers who willfully or repeatedly balance bill members will be referred by Clover to the relevant regulatory agency for further action.

Utilization Management

Our goal at Clover is to help provide the right care to your patients at the right time. Our utilization management (UM) program was designed to apply evidence-based criteria to our clinical decision making to ensure members have access to quality care that is medically necessary.

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PRE-AUTHORIZATION REVIEW

At Clover, we want doctors to do what doctors do best—care for their patients. Submitting and following up on pre-authorization requests can be time consuming and frustrating for providers and their staff. Not anymore. Not with Clover.

Pre-authorization is required to assess the need for an elective admission, procedure, or service; however, it is not required for emergency services care. A provider is available immediately for emergency services and on a timely basis for all other cases as required by the medical needs of the situation. The provider is under the clinical direction of the physician responsible for medical services provided to the members. Such determinations are made in accordance with clinical and medical necessity criteria.

As a contracted provider, if you do not obtain pre-authorization before providing the service, the claim for services can be denied and you, as the provider, can be held financially responsible.

Clover does not apply pre-authorization requirements and utilization controls that effectively withhold or limit medically necessary services, or establish pre-authorization requirements and utilization controls that might result in a reduced scope of benefits for a member.

Clover's approval of a pre-authorization does not guarantee payment of all procedure codes that are provided on your claim submission.

Pre-authorization submission

Pre-authorization requests can be submitted 24 hours a day, 7 days a week. Clover staff are available to respond to authorization requests 8 am–5:30 pm, local time, Monday–Friday.

Our online pre-authorization tool lets you securely submit new requests and check the status of requests on our website. You don't even need a special login. You simply submit requests using your National Provider Identifier (NPI). There's no need to wait on hold or to send documents by fax. Then you can log in any time to check the status of your request.

To submit a new pre-authorization request or to check if a pre-authorization is needed:

1. Log on to www.cloverhealth.com/providers.
2. Click the **Start request** button.
3. Enter the required information about the procedure and the patient, and upload any documentation.
4. Click the **Submit request** button.
5. Be sure to write down the Request ID.

To check the status of a pre-authorization request:

1. Log on to www.cloverhealth.com/providers.
2. Click the **Check request status** button.
3. Enter the Request ID you received and the National Provider Identifier (NPI) you used on the original pre-authorization submission.

Alternatively, you can call or fax your pre-authorization request to Clover:

- Call: **1-888-995-1690**
- Fax: **1-800-308-1107**

Timeliness of pre-authorization requests

UM staff can make approval determinations. However, only a licensed physician under the clinical direction of Clover's medical director with knowledge of the requested service, or an appropriately qualified and licensed designee can make a denial determination based on medical necessity or experimental/investigational services.

Failure by Clover to make a determination within the required time periods constitutes an adverse organization determination and can be appealed.

Urgent or expedited pre-authorization requests

Clover resolves urgent or expedited pre-authorization requests within 72 hours of receipt. Providers will be notified of the determination by phone and/or in writing in the case of urgent or expedited requests. If a phone call or fax notification is unsuccessful or a phone number or fax number was not provided, notifications will be mailed.

Written notification of adverse determinations includes instructions regarding reconsideration options, an explanation of the reason for the determination, and other rights and information. Clover reserves the right to convert a request for expedited processing to a standard/routine time frame if you do not state why applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Standard pre-authorization requests

Determinations are communicated to providers within a time frame appropriate to the medical exigencies of the case, but not more than 14 calendar days after the request for pre-authorization was received. You are notified of the determination by fax in the case of standard requests. If a fax notification is unsuccessful or a fax number is not provided, notifications will be made by phone and/or physical mail.

Written notification of adverse determinations includes instructions regarding reconsideration options, an explanation of the reason for the determination, and other rights and information.

Request for information

If Clover requires additional information to make a determination, Clover will notify the provider by phone, fax, email, or other means of written communications within the time frames for issuing a determination and will identify the specific information required.

If you fail to respond to Clover's request for additional information necessary to render a determination, the request for authorization will be denied.

CONCURRENT REVIEW

Concurrent review is conducted on hospitalizations and other services that require review for continued care, including UM decisions (approvals or denials) made within 48 hours of admission or within 1 business day of receiving all pertinent information to render a determination. Information needed for hospitalization can include:

- Case management (CM)
- Utilization review (UR) notes
- Emergency department notes
- Attending physician records
- Laboratory results
- Radiology reports
- Consultation notes

If a member's discharge is expected to be greater than the length of stay as determined in the preceding decision, clinical documentation must be provided to support the continued stay.

For concurrent review of inpatient psychiatric hospitalizations, partial hospitalization programs, and intensive outpatient programs, a UM decision is made within 24 hours of admission or within 1 business day of receiving all pertinent information. Clover will fax, call, or mail a notification to inform the member and provider of the results of the concurrent review.

Notifications

When an adverse determination is issued, Clover sends either of two denial notices: a "Notice of Denial of Medical Coverage" (NDMC) or a "Notice of Denial of Covered Services" (NDCS). The notices are in writing and meet the language and format requirements to ensure understanding.

The Notice of Denial of Medical Coverage form is used for denials of pre-service authorization requests and indicates the following for both the member and provider:

- The effective date of the denial, reduction, stoppage, or termination of service, or other medical coverage determination
- The action taken by Clover on the request for pre-authorization and the reason for such action, including clinical rationale
- A member's right to a standard or expedited appeal and the right to appoint a representative who will act on the member's behalf
- The availability, upon request, of the clinical review criteria relied upon to make the determination
- A member's right to have benefits continued pending resolution of the appeal and to request that benefits be continued

The Notice of Denial of Covered Services notice is used for denials of authorization requests where the member is receiving or has received services and indicates the following for the provider:

- The effective date of the denial or other medical coverage determination
- The action taken by Clover on the request for pre-authorization and the reason for such action, including clinical rationale
- The availability, upon request, of the clinical review criteria relied upon to make the determination

To dispute a Notice of Denial of Covered Services, refer to your provider contract or the payment dispute instructions in the [Disputes, Appeals, and Resolutions](#) section of this manual.

For discontinuation of covered services that require concurrent review in regard to Skilled Nursing Facility, Comprehensive Outpatient Rehabilitation Facility, and Home Health, the Notice of Medicare Non-Coverage and Detailed Explanation of Non-Coverage are used to inform the member of the last covered day for services to be rendered and the rationale, specific to the member's condition, for why the service is being discontinued. Providers are responsible to ensure the notice is delivered to the member in a timely manner.

Administrative denials

If, based upon review of member enrollment, eligibility status, and benefits coverage, the member is found to not be eligible for the requested service, one of the following statements of administrative denial is issued:

- The member was not enrolled in a benefit plan on the date(s) of service in question
- The service being requested is not covered by the benefit plan in which the member is enrolled (e.g., benefit exclusions)

The denial notification clearly and directly addresses the member or designee to ensure the member/designee can make an informed judgment about filing an appeal or grievance with Clover. The denial notification includes the following:

- Appeals or grievances filing instructions
- Time frames within which an appeal or grievance determination must be made
- A stipulation of the member's right to designate a representative to file an appeal or grievance on his or her behalf

Peer-to-peer review for organization determinations

Providers or the Clover medical director can initiate a peer-to-peer (P2P) review prior to or after rendering a decision on an organization determination. This provides the opportunity to discuss the case with the Clover physician reviewer responsible for the determination. To initiate a P2P review request, call **1-888-995-1690**. We're available 8:30 am–5 pm local time, Monday–Friday, to assist you.

- For pre-service requests: The adverse determination that is issued on the Notice of Denial of Medical Coverage (NDMC) cannot be reversed (overturned) by a P2P discussion if conducted after the determination has been made by the Clover medical director.
- Inpatient hospitalizations: Notice of Denial of Coverage for Services (NDCS) must be based on medical necessity to qualify for a P2P review.

- Peer-to-peer is not available for non-hospitalization retrospective requests.
- For SNF, Home Health, and CORF:
 - A peer-to-peer review can be initiated after a Notice of Medicare Non-Coverage (NOMNC) is issued, when there is a change in the member's medical condition, and before the last covered date.
- Initiation of peer-to-peer review for Continued Stay Terminations is only valid if the NOMNC is received by Clover no later than 12 pm local time and on the day prior to the last covered date.
- Appeals will be filed with the Quality Improvement Organization (QIO) if there is no change in the member's medical condition after the NOMNC is issued, if the appeal request is completed by 12 pm local time and is submitted on the day prior to the last covered date, or if the appeal request is with Clover's Appeals Team and cutoff time for the QIO appeal is missed.
- For pre-service requests: The adverse determination that is issued on the Notice of Denial of Medical Coverage (NDMC) cannot be reversed (overturned) by a P2P discussion if conducted after the determination has been made by the Clover medical director.

RETROSPECTIVE REVIEW

Clover's retrospective utilization review process includes determinations of medical necessity after a service is provided, based on the same accepted standards of those for pre-authorizations and review processes for similar conditions and diagnoses.

Retrospective reviews can also be used to validate approved services in the pre-authorization process.

Clover can reverse its approval of a pre-authorized treatment, service, or procedure on retrospective review when:

- Relevant medical information presented to Clover upon retrospective review is materially different from the information that was presented during the pre-authorization review
- Clover was not aware of the existence of, or provided with, the applicable information at the time of the pre-authorization review or determination

DECISION-MAKING CRITERIA

The Clover Medical Management Committee and Quality Improvement (QI) Committee review and approve clinical criteria on a yearly or ad hoc basis. Currently, Clover utilizes the Clover Utilization Review Policies, CMS National and Local Coverage Determinations, and Milliman Care Guidelines®. This suite of guidelines covers the spectrum of inpatient, outpatient, rehabilitation, and care for medical, surgical, and behavioral health issues.

Clover consults with participating providers in adherence to Clover's medical policies, treatment protocols, medical management policies, and the like, as determined by Clover.

MEDICAL MANAGEMENT INFORMATION SYSTEM

The Medical Management Information System is a unique health information technology platform developed by our engineering, data, and medical teams to be utilized by:

- The Utilization Management Department for case development and medical necessity decision-making
- Care managers to coordinate care and develop, monitor, and modify plans of care, and check on members' gaps in care
- The Appeals and Grievances Department for processing reconsiderations and complaints
- Customer experience representatives to check eligibility and process inbound telephone pre-authorization requests

Disputes, Appeals, and Resolutions

Clover wants to ensure that as our providers, you understand your options if you have any questions about—or disagree with—a decision we’ve made about billing, claims, or pre-authorizations. This section will walk you through appeals and disputes, grievances, and more.

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PAYMENT DISPUTES

Payments that are made to our in-network providers are based on the terms of the Provider Agreement with Clover. Although second-level disputes are not applicable, a payment dispute can be filed for:

- A dispute of medical necessity or administrative determinations resulting in no payment, or
- A dispute of the amount Clover paid on a claim and a request to obtain a higher level of payment

Payment dispute submission

You can create your dispute within the contractually agreed-upon time frame, upon receipt of your remittance notice, or within 90 days if not specified otherwise in your Provider Agreement. Submissions can be made on your company's letterhead or with a [Claims Payment Dispute Form](#). You can forward your request(s) to Clover in one of the following ways:

- Fax your request to **1-888-240-7243**
- Mail your dispute to:

Clover
PO Box 471
Jersey City, NJ 07303

Along with your dispute, be sure to submit the following relevant documents:

- A copy of the original claim form
- Date(s) of service
- The basis for the dispute
- The remittance notice showing the denial
- Any clinical records or CMS documentation supporting your request for reimbursement

We make reasonable efforts to review and resolve a dispute within 60 days of receiving the [Provider Claim Adjustment Form](#) and supporting documentation. The resolution can result in reprocessing of the claim(s) and issuing an EOP and/or payment and letter of determination of the outcome of the request. All decisions made in connection with our payment dispute reviews are final.

Demonstrating good cause for late filing of dispute

If Clover does not receive the dispute within the contractually agreed-upon time frame, or as required under this Provider Manual, the dispute can be resubmitted with a [“good cause” reason and supporting documentation](#) added on the dispute form for untimely filing. If a “good cause” reason for untimely filing is not shown, Clover can dismiss the dispute as untimely. In such case, a resolution letter that explains the reason for dismissal will be sent to you. If a favorable “good cause” determination is made, Clover will issue a redetermination and send out a notification to inform you.

Medical necessity determination disputes

If the claim determination indicates that the healthcare services for which the claim was submitted were (i) not medically necessary, (ii) experimental or investigational, (iii) cosmetic (rather than medically necessary), or (iv) noncovered dental rather than medical, a Clover physician reviewer will review the dispute within the time frame listed above.

Administrative determination disputes

If the claim determination indicates that the services for which the claim was submitted involved issues not related to medical necessity, then Clover's Disputes Management Team, in consultation with our Claims Team, reviews the dispute within the time frame listed above. The following are reasons for which an administrative denial is issued:

- Missing/invalid modifier, procedure code, or provider NPI
- The diagnosis is invalid for the submitted procedure

Disputes of eligibility-related determinations

If the claim determination indicates that the person to who received the healthcare services for which the claim was submitted is ineligible for coverage because (i) the healthcare services are not covered under the terms of the relevant health benefits plan, or (ii) the individual is not a Clover member, you can submit a complaint directly to Clover's Disputes Management Team if you wish to do so.

Effectuation of a dispute

When a dispute results in additional payment to you, Clover will send you notification of the decision. The notification will include sufficient information about the disputed claim(s) and any change in reimbursement(s) made to you.

For more information about the complaint submissions process or payment disputes, contact Provider Services at **1-877-853-8019**. We're available 8 am–5:30 pm local time, Monday–Friday, to assist you.

APPEALS

Pre-service appeals

When services have not yet been rendered, a member, a member representative, and you or any other provider acting on behalf of the member with the member's consent can appeal any adverse determination made by Clover's Utilization Management Team that resulted in a denial, termination, or other limitation of covered healthcare services.

For Clover members, the appeal is reviewed internally by Clover (Stage 1 appeal) and a formal external review (Stage 2 appeal) by an Independent Review Entity (IRE). Further stages of appeals include an Administrative Law Judge hearing, a Medicare Appeals Council review, and a judicial review.

Stage 1 appeals must be requested within 60 days of receipt of an adverse benefit determination. Stage 2 appeals are sent by Clover to an IRE within 30 days of receipt of the original pre-service reconsideration.

Pre-service appeals can be submitted in writing or verbally. Written appeals can be submitted to:

Clover
PO Box 471
Jersey City, NJ 07303

Verbal appeals can be initiated by calling Provider Services at **1-877-853-8019**. We're available 8 am–5:30 pm local time, Monday–Friday, to assist you.

Appeals (reconsiderations) involving medical necessity are reviewed by Clover staff members who are licensed healthcare professionals. If Clover issues a partial or fully denied determination, that determination is made by a physician who has a current and unrestricted license to practice medicine and who was not involved in the original determination.

Expedited pre-service appeal

You are allowed to submit an expedited appeal in the following situations:

1. For continued or extended healthcare services
2. For procedures, treatments, or additional services provided for a member undergoing a course of continued treatment as prescribed
3. When you determine a member's life, health, or ability to regain maximum function is at stake
4. When you and/or Clover determines the member had received an unfavorable decision for care

If Clover requires information necessary to conduct an expedited appeal, Clover immediately notifies the member and you by phone or fax.

Clover will make a determination on expedited appeals within 72 hours of receiving your request and communicate the determination to the member and/or the member's designee, and you—as provider—acting on behalf of the member. Responses are made by phone and then by mail within 3 calendar days of the communication.

Under certain circumstances, Clover can extend the time frame for an expedited appeal determination by up to 14 calendar days at either the member's request or Clover's. Clover will inform the member of his/her right to file an expedited grievance, should he/she not agree with the request for an extension.

If Clover fails to make an appeal determination within the 72 hours, such failure constitutes an affirmation of Clover's initial adverse determination and Clover forwards the entire file to the IRE. If the initial adverse organization determination is affirmed, the member, member's designee, and/or you—acting on behalf of the member—are notified and the case is forwarded to the IRE with a detailed explanation.

If Clover does not accept the request for an expedited appeal, Clover sends notice to the member or member's designee within 24 hours of the appeal receipt to notify of the conversion from expedited to the standard time frame. Clover provides an explanation of the member's right to file an expedited grievance and to submit additional supporting information from you explaining the basis for the expedited request.

Clover does not expedite post-service disputes involving payment.

Standard pre-service appeal

Standard appeals are available for pre-service issues. These appeals must be filed verbally or in writing by the member or the member's designee, or by you—as the provider—acting on behalf of the member. A standard appeal can be made within 60 calendar days of an initial adverse determination. Clover can grant a good-cause late filing exception under certain circumstances.

Clover sends a written acknowledgment of receipt of the appeal to the appealing party within 5 calendar days of the date of the receipt. If the plan requires information to conduct the appeal, the plan identifies and requests the necessary information from the member and from you, as the member's provider. Clover assigns a clinical peer reviewer different from the one who rendered the adverse determination.

The appeal determination is rendered within 30 calendar days from receipt of the request for an appeal. If the initial adverse organization determination is affirmed, the member, member's designee, and/or you—acting on behalf of the member—are notified and the case is forwarded to the IRE with a detailed explanation. If Clover fails to make an appeal determination within the applicable time periods, such failure constitutes an affirmation of Clover's initial adverse determination and Clover forwards the entire file to the IRE.

Higher-level appeals

Medicare Advantage members' cases are automatically sent to the Independent Review Entity (IRE) when an original adverse determination is upheld as a result of a pre-service appeal process and the member is notified.

Files are sent to the IRE within 30 calendar days of receipt of the request for a standard pre-service appeal and within 24 hours of the final adverse determination for an expedited pre-service appeal.

If the IRE reverses a final adverse determination, Clover must approve or provide the services no later than 14 calendar days from the standard pre-service appeal overturn date or 72 hours from the expedited appeal overturn date.

If the member, member designee, or you—acting on behalf of the member—are dissatisfied with the determination of the IRE, the member, member designee, or you can request within 60 calendar days of receipt of the IRE adverse determination a hearing with the Administrative Law Judge (ALJ), provided that the minimum monetary threshold is met.

If the member and member designee or you—acting on behalf of the member—are not satisfied with the ALJ determination, either party can request within 60 calendar days of receipt of the ALJ determination a review by the Medicare Appeals Council (MAC). The request should be sent to the following address:

**Department of Health and Human Services Department Appeals Board,
MS6127 Medicare Appeals Council**

330 Independence Avenue, S.W. Cohen Building, Room G-644, Washington, DC 20201

If the member and member designee or you—acting on behalf of the member—are not satisfied with the MAC determination, either party can request, within 60 days of receipt of the MAC determination a judicial review, provided that the minimum monetary threshold is met.

Furthermore, any reconsideration can be requested to be reopened in 1 to 4 years after final determination, depending on the circumstance.

Documentation for clinical appeals

When submitting a reconsideration to Clover for review, clinical information is required to reconsider the original medical necessity determination.

Pre-service appeals

If an initial pre-service organization determination was denied due to lack of medical necessity, the most recent and relevant clinical information is required to make a reconsideration of the appeal. Be sure to include the clinical information you believe constitutes medical necessity.

For outpatient procedures, this includes the most recent physician notes and medication lists required for the requested procedures. Similarly, for *prospective inpatient procedures*, the most recent physician notes and orders relevant to the requested services should be submitted with the appeal. For *inpatient rehabilitation*, the most recent physical and occupational therapy, and nursing notes within the last 48 hours are required.

Post-service disputes

Clover provides you the opportunity to file a post-service dispute when you disagree with a payment(s) you received from Clover after rendering a service to our members. Clover will deny any post-service dispute for services we've denied through our pre-authorization process and/or for services that require an authorization but for which there is no authorization on file. Be sure to include medical records that support medical necessity in addition to a completed payment dispute form for any inpatient stays that you are disputing for payment; for example:

- Emergency room records
- Admission history and present illness
- Inpatient specialist/physician consultation notes
- Electrocardiogram (EKG/ECG) reports
- Procedure reports

- Vitals, nursing notes
- Labs
- Radiology reports
- Medication administration records
- Medicine reconciliation form
- Physical therapy/occupational therapy/speech therapy evaluation and notes
- Discharge planning details
- Discharge summary
- Discharge medication list
- Discharge status (e.g., home, SNF, SAR, etc.)

Post-service dispute submission

For any other services that fall under *outpatient*, *prospective inpatient*, or *inpatient rehabilitation*, see the Pre-Service Appeals section. You can submit medical records in one of the following ways:

- Fax your request to **1-262-834-3589**
- Mail the medical records to:

Clover
PO Box 471
Jersey City, NJ 07303

Provider complaints not involving claims payment or medical necessity issues

If you have complaints or disputes that are not within the scope of the Claims Payment Disputes sections and do not relate to compensation matters, a claim determination, or a utilization management decision, you should first seek to informally resolve them by contacting Provider Services at **1-877-853-8019**. A Provider Services representative will work with you, and if the dispute is not resolved on an informal basis, you can submit a formal written complaint to:

Clover
Attention: Director, Network Management
PO Box 471
Jersey City, NJ 07303

While the initial, informal channel described above is made available to you, you also have the option of submitting formal complaints directly to the address above without having previously tried to resolve the matter informally.

Upon receipt of a formal, written provider complaint, Clover conducts an internal review at no cost to you.

Clover uses commercially reasonable efforts to complete the internal review and communicate the results of such review in writing within 30 business days of receiving the complaint. The written response will include:

- The names, titles, and qualifying credentials of the persons participating in the internal review
- A statement of your complaint
- The decision of the reviewer(s), together with a detailed explanation of the basis for such decision (if applicable)
- A description of the evidence or documentation that supports the decision

GRIEVANCES

Member grievances and resolution overview

Federal law guarantees Clover members the right to file complaints if they are dissatisfied with their coverage. Medicare has established a variety of rules around how members should file complaints and how Clover must process them fairly. A Clover member cannot be disenrolled or penalized in any way for making a complaint. Depending on the subject, a complaint is handled as an organization determination, an appeal, or a grievance.

A grievance is any expression of dissatisfaction regarding the health plan and/or provider, including quality of care, concerns, disputes, and requests for reconsideration or appeal made by the member or the member's representative.

Filing a member grievance

Clover members or their representatives—with the member's consent—can file a grievance in one of the following ways:

Phone

Call our Customer Experience Department at **1-866-509-0919 (TTY 711)**. We're available 8 am–8 pm local time, 7 days a week to assist you. Alternate technologies (for example, voicemail) will be used on the weekends, and holidays from April 1 through September 30.

Fax

Grievances can be faxed to **1-551-227-3962**.

Mail

Grievances can be mailed to the following address:

Clover
Attention: Quality and Grievances
PO Box 471
Jersey City, NJ 07303

Notification

Clover contacts members (by phone or mail) to acknowledge their grievance within 5 calendar days of receiving it. We are required to notify members of the results of our investigation no later than 30 days after we receive their grievance. However, in some occasions, after the conclusion of the 30 days, Clover can initiate an extension of up to 14 calendar days in order to appropriately resolve the grievance. Clover members are notified in writing if an extension is taken.

Clover members also have the right to file complaints directly with Medicare by filling out the [Medicare Complaint Form](#).

Care Management Program

One of the core components of our company is our care management program, which includes our customer experience and clinical care visit teams. Here, you'll see how this vital ecosystem works—in unison with your guidance and expertise—to deliver better patient outcomes.

PREVENTIVE HEALTH AND CHRONIC CARE MANAGEMENT

Clover works with you and with members to improve members' well-being by encouraging them to pursue healthy lifestyles. This includes ensuring that members obtain needed immunizations and screenings, empowering members to actively participate in the management of the signs and symptoms of their chronic conditions, and encouraging them to maintain optimal wellness.

As part of these initiatives, Clover focuses on the following clinical areas:

- Behavioral health
- Breast health and mammography
- Cholesterol management
- Colorectal cancer screening
- Diabetes management
- Drug and alcohol use screening
- Hypertension management
- Influenza and pneumonia vaccinations
- Medication management and safety
- Osteoporosis and musculoskeletal health
- Prevention of hospitalizations and readmissions
- Respiratory assessment (spirometry)
- Physical activity

CLINICAL PRACTICE GUIDELINES

Clover encourages the use of clinical practice guidelines (CPGs) for assistance in the treatment of acute, chronic, and behavioral health issues. However, they are not intended as a substitute for your professional assessment, but rather as tools to help in the management of certain types of clinical care.

Clover's CPGs are evidence-based and were adopted from nationally known organizations such as the Advisory Committee on Immunization Practices, the American Academy of Family Physicians, the Agency for Healthcare Research and Quality, the American Cancer Society, and the American Diabetes Association. They are reviewed annually by Clover's Medical Management Committee. All guidelines reflect the most current views of the relevant medical community as gleaned from the scientific evidence, professional standards, and expert opinion from recognized sources. The areas covered by these guidelines include:

- Diabetes management
- Cardiac care
- Heart failure prevention/treatment
- Cholesterol management
- Hypertension management
- Chronic obstructive pulmonary disease treatment/management
- Detection and treatment of depression

- Substance abuse screening and counseling
- Osteoporosis treatment
- Low back pain treatment/management
- Tobacco cessation
- Adult obesity issues
- Asthma treatment/management
- Disease prevention for adults

For the most up-to-date clinical practice guidelines, visit the Provider Portal on the Clover [website](#). You can also contact Provider Services at **1-877-853-8019**. We're available 8 am–5:30 pm local time, Monday–Friday, to assist you.

Quality Improvement Program

We're a data-driven company, focused on the care of your patients. We use the data we have and our analysis of it to continually evolve and adapt to meet your needs. We designed our Quality Improvement Program to hold ourselves to the highest standards in quality of care.

GOALS AND OBJECTIVES

We strive to continually improve the quality of care and service members receive. To that aim, the specific goals of our Quality Improvement (QI) Program are to:

- Act on opportunities for improvement on the health status of members through the development and implementation of health promotion, preventive health education, and disease and case management programs
- Maximize safety and quality of healthcare delivered to members through the continuous quality improvement process
- Maintain a high-quality provider network through a formalized credentialing and recredentialing process
- Ensure that adequate resources are arranged to provide available, appropriate, accessible, and timely healthcare services to all members according to evidence-based guidelines
- Ensure appropriate coordination of care between clinical and behavioral health providers within various clinical areas, and ensure appropriate discharge planning
- Ensure easy and timely access to accurate information through customer experience representatives, written materials, and our website
- Resolve inquiries, complaints, grievances, and appeals in a timely manner
- Maintain compliance with local, state, and federal regulatory requirements

Furthermore, our QI Program is designed to assess and improve Healthcare Effectiveness Data and Information Set (HEDIS) and Medicare Stars scores, member satisfaction based on the CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey and HOS® (Health Outcomes Survey) to implement initiatives that improve members' safety.

MEDICARE STAR RATING SYSTEM

The Medicare star rating system is used by CMS to rate the quality of Medicare Advantage plans on a 1- to 5-star scale (5 representing the highest and best score) and to allow members to compare plans. Clover's program is designed to ensure that the quality-of-care opportunities that are identified as priorities by CMS are comprehensively covered.

Star ratings are focused around key goals for the quality provision of healthcare, including:

- Effectiveness of care
- Access/availability of care
- Experience of care
- Utilization of services and relative resource use

HEDIS

HEDIS is a set of standardized performance measures created by the National Committee for Quality Assurance (NCQA) to report and compare health plans on the basis of quality of care, services, and performance. Clover uses its HEDIS reporting to assess, compare, and report the quality of care that Clover and its contracted providers, practitioners, and delegated entities provide to Medicare Advantage members. CMS Star rating system is based in part on these measures. HEDIS measures included in the Star rating calculation are:

- Breast cancer screening
- Colorectal cancer screening
- BMI assessment
- Osteoporosis management in women after a fracture
- Diabetes care: A1c, retinal eye exam, kidney disease monitoring
- Rheumatoid arthritis management
- Medication reconciliation after discharge
- Plan all cause readmissions
- Statin therapy in persons with cardiovascular disease

When applicable, Clover asks that you adhere to HEDIS guidelines and specifications for all members during each measurement year and to collaborate in the data collection process by facilitating Clover staff access to members' medical records. Clover will communicate HEDIS results to members and to you to encourage the use of preventive measures and thus improve healthy behaviors and outcomes.

CAHPS

CMS requires Medicare Advantage plans to administer the patient satisfaction survey called Consumer Assessment of Healthcare Providers and Systems (CAHPS). The CAHPS survey is sent to a random sample of members in the spring. Several questions relate to patient satisfaction with physicians. CAHPS includes questions about the patient-physician relationship, such as:

- Coordination of care: measures patients' perception of their personal physicians' knowledge about the care received from specialists and other healthcare providers
- Getting care quickly: measures the experiences patients had in receiving care or advice in a reasonable time, including time spent in waiting rooms
- Getting needed care: measures the experiences patients had when attempting to obtain care, treatments, and tests from their PCP and specialists
- Getting needed prescription drugs: measures the experiences patients had when attempting to fill a prescription at a local or mail-order pharmacy
- Rating of healthcare: gives patients an opportunity to rate all the healthcare they have received in the last 12 months
- Rating of health plan: measures patients' overall experiences with their health plan over the last 12 months
- Rating of the drug plan: measures patients' overall experiences with drug plan over the last 12 months

HOS

The Health Outcomes Survey (HOS) is a CMS survey that gathers health data from Medicare participants over time. A random sample of Medicare patients are selected and the surveys are administered in the spring. HOS includes a baseline survey, and 2 years later a recheck survey is sent to the same patients. Patients are asked about overall physical and mental health status. Patients are also asked if they had a discussion with their physician about:

- Urinary incontinence
- Physical activity
- Fall risk
- Pharmacy measures
- Pharmacy measures take into consideration adherence to medications prescribed to treat different disease states, including:
 - Diabetes
 - Hypertension
 - Hypercholesterolemia

Actions taken by Physicians to improve medication adherence include:

- Proactively assessing whether the patient is taking medication as prescribed. Many times patients will split pills or take them irregularly. Encourage patients to take medications as you prescribe them and do not encourage patients to split pills unless instructed to do so as part of the prescription.
- Discussing patient-specific adherence barriers. Many times patients have transportation issues getting to a pharmacy. Discussing a mail-order option may work better for chronic medications.
- Providing 90-day prescriptions for maintenance medications.

If you have questions, you can contact Provider Services at **1-877-853-8019**. We're available 8 am–5:30 pm local time, Monday–Friday, to assist you.

PROGRAM REVIEW

Clover's Star rating strategy is consistent with CMS's aims of better care, healthier people and communities, and lower cost through continuous improvement.

Our interdisciplinary Quality Improvement Committee is tasked with reviewing and analyzing QI activities at Clover for impact and effectiveness. With that aim, we work with our provider network to promote best practices, which employ evidence-based guidelines, and to make modifications to our program when opportunities for improvement are identified.

THE CLOVER ASSISTANT PROGRAM

The Clover Assistant Program (CA Program) is designed to improve care outcomes and efficiency of care by providing you with real-time access to actionable data on your patients at the point of care. The Clover Assistant is built on a proprietary software platform that aggregates and integrates health data across every spectrum of the member's healthcare experience, from lab and utilization management requests to customer experience encounters. This web-based clinical decision support tool, which also analyzes patient behavior and needs, helps drive insights and showcases timely information to help you ensure Clover members get the right care at the right time.

As providers, you agree to partner with Clover, as part of the CA Program, to provide care management of Clover members and coordinate their care across the healthcare continuum. You agree to:

- Participate in training on the Clover Assistant, in order to understand how best to make use of the Clover Assistant in the treatment and management of patient care; and
- Make use of Clover Tools and Technologies for any and all evaluation and management, and annual wellness visits.

If you are a participating provider, the CA Program also compensates you for using the Clover Assistant to help support your care delivery and decision-making process. Under the CA Program, you agree to use the Clover Assistant as directed by Clover for any and all member visits for healthcare services at the time of the patient encounter. Clover will remit a Clover Assistant Payment within 7 days for use of the Clover Assistant during the office visit. You agree to accept the Clover Assistant Payment for performing an evaluation and management (CPT 9920x, 9921x, 99385, 99386, 99387, 99395, 99396, 99397), physical exam (CPT G0402), and annual wellness visit (CPT G0438 and G0439). Member expenses are not affected by this Program.

Providers interested in learning whether they are eligible for the Clover Assistant Program may contact the Network Engagement Team at clover.network@cloverhealth.com for additional information.

Pharmacy Services

We want to ensure your patients have the most cost-effective prescriptions and drug therapy treatments available to them. That is why, in addition to providing unique offerings like 100-day prescriptions, we make sure to contract with the highest-quality pharmacies to administer them.

FORMULARY OVERVIEW

Clover contracts with CMS to provide drug coverage for Medicare Part D members using the Medicare Part D Drug Formulary, utilization management programs, and pricing structure. The pharmacy benefit does not cover all medications. Some medications require prior authorization or have limitations on age, dosage, and/or maximum quantities. Clover works with CVS Caremark to administer pharmacy benefits, including the prior authorization process.

The Clover Medicare Advantage Formulary contains all drugs covered by our plans, and is organized by section. Each section is divided by therapeutic drug class primarily defined by mechanism of action. Products are listed by generic name or by brand name, depending on formulary coverage. Unless exceptions are noted, generally all applicable dosage forms and strengths of the drug cited are included in the Clover Medicare Advantage Formulary.

Medications selected for inclusion in the Clover Medicare Advantage Formulary are reviewed by Clover's Pharmacy Benefit Manager's pharmacy and therapeutics committee (P&T). Members of the P&T come from various clinical specialties and are practicing physicians and pharmacists. The P&T meets regularly to keep the formulary current, while providing optimal results for our members and controlling the cost of medication therapy.

Formulary documents can be found on the Clover website: cloverhealth.com/en/members/formulary.

PART D UTILIZATION MANAGEMENT

Certain prescription drugs on the formulary have additional requirements or limits on coverage. These requirements and limits ensure that members use these drugs in the most effective way and help to control drug costs.

Certain drugs require prior authorization. This means that you will need to get approval from us before the members fill their prescription. If you don't get approval, we cannot cover the drug.

Prior authorization criteria can be found on the Clover website: cloverhealth.com/en/members/formulary.

Quantity limits

For certain drugs, there are limits on the amount we will cover per prescription or for a defined period of time.

Step therapy

In some cases, we require the members to try one drug for treatment of a condition before we cover another drug for the same condition. For example, if Drug A and Drug B both treat a certain medical condition, we can require you to prescribe Drug A first. If Drug A does not work for the member then we will cover Drug B.

More about step therapy can be found on the Clover website: cloverhealth.com/en/members/formulary.

2019 FORMULARY-LEVEL OPIOID POINT-OF-SALE SAFETY

Beginning January 1, 2019, Clover's drug management program implemented several pharmacy-based edits to assist in addressing safety concerns regarding opioid prescriptions.

To align with CMS Medicare Part D Opioid Overutilization Policy, we partnered with our pharmacy benefits manager CVS/Caremark and developed point-of-sale edits to advocate patient safety for our members and encourage appropriate prescription opioid use.

The drug management program or point-of-sale edits are not intended as prescribing limits.

Summary: 2019 Med D opioid management requirements

7-day supply edit for opioid-naïve patients

- Hard reject for initial opioid prescription (short- and long-acting) for acute pain exceeding 7 days
- 60-day minimum look-back period; CVS/Caremark implementing a 90-day look back
- Safety edit, not transition fill eligible
- Patients in active cancer treatment, LTC residents, patients in hospice or palliative care, and Buprenorphine for medication-assisted treatment (MAT) are exempt from edit

Update 90 mg/day MME soft reject (care coordination edit)

- Plans must implement cumulative 90 mg/day MME soft edit
- Long-term care residents, patients in hospice or palliative care, patients in active treatment for cancer-related pain, and Buprenorphine for MAT are expected to be excluded from edit

Opioid/benzodiazepine POS (point of service) soft reject edit

- Soft reject POS safety edit for the concurrent use of opioids and benzodiazepines

Duplicate long-acting opioid POS soft reject edit

- Soft reject POS safety edit

Additional CVS Health opioid changes for standard Med D formularies

- Immediate Release before Extended Release prior authorization
- Quantity limits for opioid-containing products based on limitations of up to 90 MME/day (when possible) and/or the FDA-approved maximum dose
 - MME = morphine milligram equivalent

CVS Health implementation details: 7-day limit for opioid naïve patients

CMS Mandate for 2019 for opioid naïve patients: All Med-D plans are expected to have a hard reject for an initial opioid prescription for acute pain that exceeds 7 days; patients in active cancer treatment, hospice, LTC, palliative care are excluded from this edit.

Edit overview

- Hard reject for opioid-naïve patients filling over 7-day supply of opioid (safety edit, not transition fill eligible)
- Buprenorphine products for medication-assisted treatment for opioid use disorder not subject to this edit
- Edit will reject with reject code 925 (Initial Fill Days Supply Exceeds Limits—new reject code for 2019) and 569 (Provide Notice: Medicare Prescription Drug Coverage and Your Rights) upon initial rejection
- Once 7-day reject is resolved, all opioid formulary or UM rejects with Transition Fill (TF) logic will execute applicable Transition Fill logic

Ensuring access for patients excluded from edit and avoiding unnecessary disruption

- Exception criteria will apply and allow member to bypass 7-day edit for members in:
 - Active cancer treatment using oncology GPIs or cancer ICD 10 diagnosis codes
 - Long-term Care using patient residence codes 03 or 09
 - Hospice using member-level indicator
 - Palliative care using ICD 10 code Z51.5
- CVS Health Pharmacy Help Desk can override edit if exception cannot be determined based on prescription claim/member data; conversation will be documented

CVS Health implementation details: improving dur (drug utilization review) controls in Part D

CMS mandate for 2019: POS DUR edits

- Cumulative Morphine Milligram Equivalent (cMME) soft reject edit at 90 mg/day MME
 - Plans may have an optional hard reject at a cMME of ≥ 200 mg/dayMME
- Soft reject for the concurrent use of an opioid and benzodiazepine and duplicate long-acting opioids

Edit overview

Current POS MME edit updated to meet new opioid coordination of care safety edit requirements:

- New result of service override codes allow pharmacist to override edit—if appropriate—after consultation with prescriber, or if the pharmacist has documented an appropriate exception for edit
- Will change reject code 88 to add new MME reject code 922 (Morphine Equivalent Dose Exceeds Limits)
 - Optional hard reject at >200 mg/day MME will include G4 (Prescriber Must Contact Plan) with the 922
- Members excluded from edit include:
 - Hospice - using the member-level indicator
 - Long-term care (LTC) - using appropriate patient residence codes 03 (Skilled Nursing Facility) and 09 (Intermediate Care Facility/Individuals with Intellectual Disabilities)
 - Active treatment for cancer-related pain using oncology GPIs with 180 day look-back
 - Members receiving buprenorphine for medication-assisted treatment (MAT) using MAT GPIs

Two new soft reject POS safety edits:

- Concurrent use of opioids and benzodiazepines edit (using current drug-drug interaction edit functionality)
- Duplicate long-acting opioids edit (using current duplicate therapy edit functionality)

We request that you respond promptly to pharmacy requests for additional information related to opioid safety alerts. Please ensure your on-call staff is aware and responds with a sense of urgency to pharmacy outreach. This will avoid delays in needed drug therapy.

If you have questions, please call the CVS Caremark Help Desk number on your patient's Clover Health member ID card. For PPO plans, call **1-855-479-3657**. For HMO plans, call **1-844-232-2316**.

MEDICARE ADVANTAGE PART D FORMULARY COVERAGE EXCLUSIONS

The following is a list of noncovered (i.e., excluded) drugs and/or categories:

- Agents when used for anorexia, weight loss, or weight gain (even if used for a noncosmetic purpose, such as for morbid obesity)
- Agents when used to promote fertility
- Agents when used for cosmetic purposes or hair growth
- Agents when used for the symptomatic relief of cough and colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Nonprescription over-the-counter (OTC) drugs
- Covered outpatient drugs that the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Agents when used for the treatment of sexual or erectile dysfunction; erectile dysfunction drugs will meet the definition of a Part D drug when prescribed for medically accepted indications approved by the Food and Drug Administration (FDA) other than sexual or erectile dysfunction (such as pulmonary hypertension). However, ED drugs will not meet the definition of a Part D drug when used off-label, even when the off-label use is listed in one of the compendia found in section 1927(g)(1)(B)(i) of the Act: American Hospital Formulary Service Drug Information, and DRUGDEX® Information System.

2019 Medicare Part D coverage phases

Medicare Part D prescription drug plans have four coverage stages. How members are affected depends on their prescription drug plan and medication costs. If their plan has a deductible, the member's responsibility begins at Phase 1. If their plan does not have a deductible, the member's responsibilities begin at Phase 2. The dollar amounts listed below can change each year.

You can log into [NaviNet](#) or reference the Benefits section of this manual to determine if the member has a Part D deductible on his or her plan.

Phase 1: Deductible	Phase 2: Initial Coverage	Phase 3: Coverage Gap	Phase 4: Catastrophic Coverage
<ul style="list-style-type: none"> The member pays 100% of the drug cost until the annual deduction is satisfied. 	<ul style="list-style-type: none"> The member and Clover will pay medication costs until the shared total equals \$3,750. The member will pay the applicable copay and coinsurance during this stage. 	<ul style="list-style-type: none"> The coverage gap is commonly referred to as the “Donut Hole” and begins when the member’s total drug costs have reached \$3,820. While in this stage, the member will pay a maximum of 25% of the cost of brand name medications, or a maximum of 37% of the cost of generic medications. The Coverage Gap copayments do not apply to members who have low-income subsidy. 	<ul style="list-style-type: none"> The Catastrophic Coverage Phase begins when the member out-of-pocket costs have reached the \$5,100 coverage gap limit. During this stage, the member will pay \$8.50 for brand medication or \$3.40 for generic medication, or a 5% coinsurance, whichever is greater.

PART D FORMULARY TIERS

Drugs represented in the Clover Medicare Advantage Formulary can have varying costs to the plan member. We categorize costs of prescription drugs with the following tiered format:

Tier 1

- The lowest cost-sharing tier
- Includes preferred generic drugs and some low-cost preferred brands

Tier 2

- Includes generic drugs and some low-cost preferred brands
- May have Tier 1 alternatives
- Low- to mid-range cost

Tier 3

- Includes preferred brand drugs and non-preferred generic drugs classified by Clover based on safety, efficacy, and cost
- Mid-range costs

Tier 4

- Includes non-preferred brand-name and some non-preferred generic drugs for which alternatives are available at lower tiers
- Mid- to higher-range costs

Tier 5

- The highest cost-sharing tier
- Includes specialty drugs that are typically self-injected and used to treat complex medical conditions
- Specialty drugs can require more involvement from you, require special storage and handling and/or require close monitoring

PART D COVERAGE DETERMINATIONS

What is a coverage determination?

A coverage determination is an approval or denial decision made by Clover when members ask for coverage or payment of a drug they believe Clover should provide.

You, as well as members, can ask for a coverage determination. Members can also appoint someone else (such as a relative) to request a coverage determination on their behalf.

Upon receipt of any request, Clover responds to coverage determination requests within 72 hours of routine requests and within 24 hours of expedited requests.

You must provide medical history and/or other pertinent patient information when submitting a [Request for Medicare Prescription Drug Coverage Determination](#) form for formulary exceptions.

A coverage determination request is required for:

- Drugs not listed on the formulary
- Drugs listed on the formulary with a prior authorization
- Duplication of therapy
- Prescriptions that exceed the FDA daily or monthly quantity limits, or prescriptions that exceed the permitted limit noted on the formulary
- Drugs with a step edit, where the first-line therapy is inappropriate
- A request by a member for a lower copayment tier for a prescribed drug on a higher copayment tier

The goal of the coverage determination program is to ensure that medication regimens that are high-risk, have a high potential for misuse, or have narrow therapeutic indices are used appropriately and according to FDA-approved indications.

Part D coverage determination submission

Follow these guidelines for efficient processing of your Medicare prescription drug coverage determination requests:

1. Complete the “Request for Medicare Prescription Drug Coverage Determination” form found on the [Clover website](#)
2. Fax it to CVS Caremark at **1-855-633-7673**; alternatively, coverage determination requests can also be submitted electronically at <https://www.covermymeds.com/main/>
3. Respond timely to requests for additional information. CVS Caremark will notify you of the decision by fax. If the request is approved, information in the online pharmacy claims processing system changes to allow the specific members to receive this specific drug. If the request is denied, information about the denial will be provided to you.

If the request is denied, information about the denial will be provided to you.

In the event you or a member disagrees with the decision regarding coverage of a medication, you can request a free copy of the criteria or guidelines used in making the decision and any other information related to the determination by calling CVS Caremark toll-free at **1-855-344-0930**.

PART D APPEALS

If your prescription drug coverage request is denied, you have the right to file an appeal through our Pharmacy Benefit Manager, CVS Caremark, within 60 calendar days from the date of our first decision. Standard requests must be filed in writing. We accept expedited requests by telephone and in writing.

Part D appeals submission

Follow these guidelines for efficient processing of your appeal requests:

1. Complete the Request for Redetermination of Medicare Prescription Drug Denial [form](#).
2. Fax it to CVS Caremark at **1-855-633-7673**. Wait for CVS Caremark to notify you via fax of approval; or,
3. Mail the appeal to:

CVS Caremark
Attn: Part D Appeals
PO Box 52000, MC109
Phoenix, AZ 85072-2000

Expedited Part D appeal submission

Expedited appeal requests can be made by calling the CVS Caremark Part D Appeals department at **1-855-344-0930**, 24 hours a day, 7 days a week. Speech- and hearing-impaired: call 711.

PART D GRIEVANCES

A Part D grievance is any complaint other than one that involves a coverage determination related to prescription drug benefits. A grievance is filed if Clover members have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug. Medicare Part D grievances related to the following topics are processed by Clover's contracted Pharmacy Benefit Manager (PBM) CVS Caremark:

- Benefits
- Confidentiality and privacy
- Customer service
- Exceptions
- Pharmacy network
- Quality of care
- Mail order

Part D grievance submission

Members can contact CVS Caremark at **1-855-479-3657** (PPO plans) or **1-844-232-2316** (HMO plans) to file a grievance, or mail the grievance to:

**CVS Caremark Grievances,
Medicare Part D Grievances Department,
PO Box 30016,
Pittsburgh, PA 15222-0330**

Part D grievances related to the following are handled by Clover:

- Enrollment/disenrollment
- Fraud and abuse
- Marketing
- Other premium billing
- Provider prescribing

Members can file these types of grievances using the contact information listed under the [**"File a member grievance"**](#) section of the Provider Manual.

Laboratory Services

We believe in catching conditions earlier and doing our best to prevent them from developing in the first place—and that the best way to do both is with regular lab work.

We encourage you to refer your patients' samples to Quest, our trusted laboratory partner. Search our Provider Directory for in-network labs at <https://www.cloverhealth.com/en/members/find-provider>.



Credentialing

To ensure that everyone we partner with meets the industry regulatory requirements, all Clover network providers, physicians, nonphysician healthcare professionals, and ancillary providers must get credentialed. This section will show you how.

CREDENTIALING PROCESS

If you fall under any of the following categories, you require credentialing:

- Medical doctors (MD)
- Osteopathic doctors (DO)
- Doctoral-level and master-level psychologists (PhD, MS)
- Chiropractors (DC)
- Dentists—oral maxillofacial surgeons (DMD)
- Ophthalmologists (MD)
- Podiatrists (DPM)
- Certified nurse midwives (CNM)
- Master-level clinical social workers (MSW, CSW)
- Physical therapists (PT), occupational therapists (OT), speech/language therapists (ST)
- Audiologists (AUD)
- Nutritionists and dietitians (RD)
- Certified nurse practitioners (CNP), clinical nurse specialists (CNS), nurse practitioners (NP)
- Physicians assistants (PA)

Clover's Credentialing Committee is composed of a community of physicians representing several specialties and is responsible for the approval and oversight of all participating providers. The Credentialing Committee recommendations are reviewed and acted upon by our Chief Medical Officer.

Clover can delegate credentialing and recredentialing activities as appropriate. If any portion of the process is delegated, Clover's delegated credentialing and recredentialing policies are followed. We monitor compliance with our policies and procedures of all delegated entities at least annually.

Clover completes credentialing activities for a "clean" file within 90 days of receiving a completed application and signed contract. If additional information is needed, we will reach out to you to amend or correct any incomplete or erroneous information.

INITIAL CREDENTIALING AND APPLICATION SUBMISSION

Physician and nonphysician healthcare professionals

You must send Clover a completed application form, a current signed and dated attestation of correctness and completeness not to exceed 180 days from the credentialing date, and a signed agreement. You can submit one of the following application options:

1. We strongly prefer the Council for Affordable Quality Healthcare (CAQH) application, as it ensures a compliant application and a timelier, online process. You only need to provide your CAQH ID.
2. A Universal Physician Application can be submitted, but the timeline for review can be significantly longer because the review process is manual. This particular credentialing application must include the following items:
 - a. Current attestation—CAQH requires a quarterly update
 - b. Current valid professional medical license for the practicing state
 - c. Current Drug Enforcement Administration (DEA) and Controlled Dangerous Substance (CDS) certificates for the practicing state, required for physicians and, if applicable, for that state (physicians unable to meet this requirement should provide a letter explaining why a DEA and/or CDS will not be obtained and how prescriptions will be covered)
 - d. Current Board Certification or copy of the confirmation of registration to sit for a board certification, if applicable
 - e. Current proof of adequate professional malpractice insurance with a minimum coverage amount set by the appropriate state statute
 - f. Summary of professional work history (going back a minimum of 5 years) with explanation(s) for any gaps of 6 months or more
 - g. Documentation or certificates of education and training
 - h. Summary of hospital privileges if available

In addition to an updated and complete credentialing application, the following document must also be submitted: Completed W-9 Form

During the credentialing process, we will check the following entities:

1. National Practitioner Data Bank (NPDB)
2. Applicable licensure agencies for information on sanctions or limitations on licensure
3. Office of Inspector General (OIG), Department of Health and Human Services, for the List of Excluded Individuals/Entities
4. System for Award Management (SAM) for information on providers debarred from participation or otherwise declared ineligible to participate in federal procurement or nonprocurement programs
5. Medicare Opt-Out or other federal reimbursement program for excluded or opt-out providers

Ancillary providers

You must send Clover a completed Facility/Ancillary Provider Credentialing Application that is signed and dated within 180 days of the credentialing date, as well as a signed agreement, and the following documents:

1. Current valid state operational license

2. Other applicable state/federal licenses (e.g., Clinical Laboratory Improvement Amendments [CLIA], DEA, pharmacy, or Department of Health)
3. Accreditation/certification by a governmental accrediting body (e.g., CMS, Joint Commission on Accreditation of Healthcare Organizations [JCAHO]), if applicable
4. Current general liability coverage (i.e., documentation showing the amounts and dates of coverage)
5. Medicare certification; if you are not certified, provide proof of participation
6. IRS W-9

During the credentialing review, we check the following entities:

1. National Practitioner Data Bank (NPDB)
2. Office of Inspector General (OIG), Department of Health and Human Services, for the list of excluded individuals/entities
3. System for Award Management (SAM) for information on providers debarred from participation or otherwise declared ineligible to participate in federal procurement or nonprocurement programs
4. State Medicaid Debarment

If an illegible and/or incomplete application packet is submitted, or if required attachments are missing, you will be contacted in an attempt to obtain this information. If the information is not received within 30 days, a cover letter detailing the missing or incomplete items, along with the incomplete application packet, is sent back to you.

When your initial application is approved by the Credentialing Committee, you are sent a welcome letter. If the application is denied, a decision letter that includes rights to appeal the committee's decision is sent out to you following the committee meeting.

RECREREDENTIALING PROCESS AND REVIEW

Clover requires you to undergo and complete a recredentialing review every 3 years. To qualify for recredentialing, you must maintain the same minimum qualification requirements as for the initial credentialing. A recredentialing notification letter is sent out at least 3 months ahead of the 3-year anniversary.

There is no action required of you if the Council for Affordable Quality Healthcare (CAQH) application is complete and updated; or, you can submit a universal application. If you fail to respond within 60 days of your 3-year anniversary, it is considered an administrative termination, and a termination letter is sent to you. If you are terminated as a nonresponder, you will need to undergo the initial credentialing process again, which includes the signing of a new contract.

Recredentialing applications must include the following:

- Signed and dated attestation within 180 days of the recredentialing date
- Current valid professional medical license
- Current DEA and CDS certificate for the practicing state, required for physicians and if applicable for that state

- For physicians, a letter explaining why a DEA and/or CDS will not be obtained and how prescriptions will be covered
- Current board certification or copy of the confirmation of registration to sit for a board certification, if applicable
- Current adequate professional malpractice insurance with a minimum coverage amount set by the appropriate state statute
- Summary of professional work history (going back a minimum of 3 years) with explanation(s) for any gaps of 6 months or more
- Explanation of hospital coverage arrangements, if applicable

You are encouraged to maintain up-to-date information on your CAQH or universal application.

Once the recredentialing application is received and all components are verified, you will remain in the Clover network. If you get denied when presented to the Credentialing Committee for decision making, you are notified in writing within 10 business days of the committee decision. The letter includes reasons for non-approval and indicates your rights to appeal the committee's decision. The actual termination date is not effective until the appeal process is completed and the original decision upheld. Exceptions to this rule are terminations related to quality-of-care issues where you have caused or can cause harm to members.

DELEGATED ENTITIES

Delegation is a formal process by which a health plan provides a provider group with the authority to perform certain functions on its behalf, such as credentialing. A function can be fully or partially delegated. Full delegation allows all activities of a function to be delegated. Partial delegation allows some of the activities to be delegated.

All participating providers or entities delegated for credentialing/recredentialing are to use the same Clover policies and procedures as defined in the delegated credentialing agreement. Delegated oversight audits, in person or remotely, are conducted at least annually.

Although Clover can delegate the authority to perform a function, it cannot delegate the ultimate responsibility for fulfilling the service or obligation.

CONFIDENTIALITY

The Credentialing Department is responsible for ensuring the confidentiality of all information received and maintained in the credentialing and recredentialing processes. Information derived from peer-review functions is protected from subpoena and discovery by state immunity laws, except as otherwise provided by law. This includes proceedings, reports, and records of a peer review specialty committee.

NONDISCRIMINATION

Clover does not discriminate in the credentialing or recredentialing process on the basis of religion, race, color, national origin, age, gender, sexual orientation, height, weight, familial status, marital status, disability, or any other basis prohibited by law. Additionally, Clover does not discriminate in credentialing and recredentialing based upon the types of procedures or the risks of the population that you serve.

REVIEW OF YOUR INFORMATION ON FILE

With the exception of information determined by Clover to be peer-review protected, you have the right to request in writing your file information and to subsequently review and correct any erroneous information obtained by Clover to support its evaluation of your application.

Send written requests to:

Clover
Attn: Credentialing Department—Credentialing Manager
PO Box 471
Jersey City, NJ 07303

ONGOING MONITORING

Clover is responsible for offering its members qualified and competent providers who will be accountable for delivering appropriate and medically necessary care and services. Because of this, Clover monitors provider sanctions and limitations. Clover is responsible for regularly informing you of any findings related to performance or practice of care.

The Credentialing Department is responsible for the management of ongoing (monthly) monitoring of:

- Medicare-Medicaid sanctions, which can lead to termination/suspension of Provider Agreement
- State licensure/disciplinary actions, which can lead to termination/suspension of Provider Agreement
- Quality-of-care issues, which can lead to a corrective action plan or termination

Any findings are discussed during the monthly Credentialing Committee meeting. If the Credentialing Committee denies you inclusion into Clover's network, you are notified in writing within 10 business days of the committee decision. The letter includes reasons for denial and indicates your rights to appeal the committee's decision. The actual termination date is not effective until the appeal process is completed and the original decision upheld. Exceptions to this rule are terminations related to quality-of-care issues where you have caused or can cause harm to members.

Provider Termination

While we do everything we can to nurture our partnership with you, there can be times when the only reasonable resolution is to discontinue working together. This section describes what is involved when a partnership is not serving the best interests of either party.

CIRCUMSTANCE FOR TERMINATION

There can be certain circumstances in which Clover decides to terminate its relationship with contracted or participating providers. Depending on the cause, Clover can work with you to address the problem, initiate a termination per the terms of your Provider Agreement, or initiate a termination to take effect immediately.

An immediate termination can be initiated for the following reasons:

- Suspension, revocation, condition, expiration, or other restriction of your licensure, certification, and/or accreditation to perform services contemplated under your Provider Agreement
- Suspension or bar from participation in federal healthcare programs
- Determination that you engaged in or are engaging in fraud
- Noncompliance with the general and professional liability insurance requirements set forth in your Provider Agreement
- State sanctions, indictment, arrest, or conviction, or a felony or any criminal charge
- Clover's reasonable determination that your immediate termination is necessary for the health and safety of members

Clover can also terminate the participation of an individual group provider or can require that an individual group provider cease providing services to members based upon any of the foregoing events, without terminating the Provider Agreement in its entirety.

Certain terminations initiated can also not take effect immediately (terminations for cause, terminations without cause). Refer to your Provider Agreement for details around terminations that cannot take effect immediately and the effective time frames.

In the event of a termination, Clover sends a termination notice to you, your ancillary, or your hospital. Clover can require you, your ancillary, or your hospital to provide continuity of care until a safe transition to another provider has been made.

Your Provider Agreement will not be terminated or refused renewal solely because you have:

- Advocated on behalf of a member
- Filed a complaint against Clover
- Appealed a decision made by Clover

Additionally, you can have termination rights of your own. For details about provider termination rights, refer to your Provider Agreement.

Appeal hearing process

When you, your ancillary, or your hospital requests an appeal of a termination decision, Clover's Credentialing and Termination Committee can form a sub-committee to hear your appeal. The sub-committee consists of no fewer than 3 members. Here are the rules and regulations for holding an appeals process:

- Peers can be providers or healthcare professionals outside of the Clover network of providers
- No individuals involved in the investigation of an appeals case can be part of the appeals hearing committee
- The appeals hearing committee voting can be made in person, via phone, or via email
- The medical director appoints a hearing officer who serves as the presiding officer over the hearing
- The presiding officer should:
 - Determine the order and decorum of the hearing and deliberations
 - Assure that all participants have opportunity to present oral and documented evidence
 - Provide guidance to the appeals hearing committee during the hearing and deliberations
- The hearing officer does not have voting privileges

The notice of the final decision of the appeals hearing committee is delivered by certified mail to you, your ancillary, or your hospital 30 days after close of the hearing. The notice includes the final decision, the basis for that decision (affirm, modify, or withdraw the original proposed action), and the Provider Agreement provisions and facts relied upon by Clover during the hearing.

NONRENEWAL OF CONTRACT

Unless otherwise specified, the Provider Agreement Clover executes with you automatically renews on the one-year anniversary of the effective date on your Provider Agreement, unless terminated in accordance with the provisions stated in it. A nonrenewal of your Provider Agreement constitutes a termination and will be treated as final.

CONTINUITY OF CARE

In the event of a termination, whether initiated by you or by Clover, our goal is to ensure that your patients, our members, continue to receive the care they require until they no longer require it or until a safe transition can be made (unless otherwise specified).

In the event that you voluntarily decide to leave the network, or Clover terminates with/without cause (i.e., a termination that does not fit the criteria of "immediate" as defined above), you must agree to continue to provide covered services until it is safe to discontinue or safe alternatives have been confirmed.

During this continuity-of-care period, you agree to:

1. Accept Clover's established reimbursement rates as payment in full
2. Adhere to Clover's quality improvement requirements
3. Provide medical information related to the care
4. Adhere to Clover's policies and procedures

Pre-authorization by the [Utilization Management Department](#) is required during any continuity-of-care period.

To ensure Clover stays aligned with its mission to build high-performing, cost-effective provider networks, Clover maintains discretion to select the providers with whom it decides to contract. Clover is able to make changes to these networks at any time during the contract year, as long as you can continue to furnish all Clover-covered services in a nondiscriminatory manner, meet established access and availability standards and timely notice requirements, and ensure continuity of care for members.

Administrative Procedures and Compliance

We are here to ensure your practice stays aligned with compliance guidelines, our marketing policies, and other industry-standard regulations. In the following section, we provide some helpful links and overviews to make it easy for you or your staff to reference or access them.

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CMS GUIDELINES

You and any persons involved in the administration or delivery of the Medicare program benefits must complete the following training requirements within 90 days of initial hire and annually thereafter:

- CMS Medicare Parts C and D Compliance training
- CMS Medicare Parts C and D Fraud, Waste, and Abuse (FWA) training

CMS has developed a web-based training module that can be used to satisfy these training requirements. It is available on the CMS Medicare Learning Network (MED Learn) [website](#).

Clover recommends that you read and understand the guidelines set forth by the Centers for Medicare and Medicaid Services. For additional information, visit [cms.gov](#).

MARKETING PLANS

You cannot develop materials that market Clover without Clover's prior written approval, but you can use CMS-approved materials supplied directly by Clover. Under Medicare Advantage program rules, Clover and other Medicare Advantage plans must follow CMS marketing guidelines and obtain CMS review and approval for all marketing materials before making such materials available for distribution to eligible individuals.

You can have Clover marketing materials, including brochures, posters, or notifications, available in your office as long as Clover is not exclusively represented. Materials for other Medicare Advantage plans in which you are a participant must be available as well and in the same location. Medicare Advantage marketing materials can only be displayed in common areas and not in private patient exam rooms.

If you are interested in Clover marketing materials to share with members, contact your Clover representative.

If a member has a question regarding Clover, direct the member to call Clover Customer Experience at **1-888-778-1478** (TTY 711). We're available 8 am–8 pm local time, 7 days a week, to assist you. Alternate technologies (for example, voicemail) will be used on the weekends, and holidays from March 1 through September 30.

AUDIT

Providers must ensure compliance with Medicare laws, regulations, and CMS instructions; agree to audits and inspections by Clover, CMS, and/or its designees; cooperate, assist, and provide information as requested; and maintain records for a minimum of 10 years.

CONFLICT OF INTEREST POLICY

Conflicts of interest are created when an activity or relationship renders you unable or potentially unable to provide impartial assistance or advice, impairs your objectivity, or provides you with an unfair competitive or monetary advantage. Many of the relationships discussed in this document are subject to conflict-of-interest disclosure policies. Even if the relationships are legal, you can have an obligation to disclose their existence.

Glossary

Abuse: Actions that can, directly or indirectly, result in unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Appeal: Any of the procedures that deal with the review of adverse organization determinations on the healthcare services the member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the healthcare services.

Covered services: Medically necessary healthcare services to which the member is entitled under the terms of the member’s benefit agreement.

Fraud: Knowingly and willfully executing or attempting to execute a scheme or artifice to defraud any healthcare benefit program, or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit program.
18 U.S.C. § 1347.

First-tier, downstream, and related entities: Includes contracted physicians, healthcare professionals, facilities and ancillary providers, as well as delegates, contractors, and related parties of the Plan.

Grievance: Any complaint or dispute expressing dissatisfaction with the manner in which Clover or one of its delegated entities provides healthcare services, regardless of whether any remedial action can be taken.

Group/group provider: Employees, affiliates, or any individuals contracted with a group to provide covered services to a Clover member.

Healthcare provider: Physicians, healthcare professionals, and/or other providers licensed and/or authorized under the laws of the state in which services are provided who are employed by or contracted by Clover.

Medically necessary services: Services that are necessary for the diagnosis or treatment of disease, illness, or injury, and without which the member can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort.

Member benefit agreement: The agreement between Clover and the member that details the benefits to which the member is entitled.

Organization determination: Receipt of, or payment for, covered items or services; the amount Clover requires an enrollee to pay for covered items or services; or a limit on the quantity of covered items or services.

Participating provider: A healthcare provider, hospital, healthcare facility, ancillary provider, or any other person or entity who has contracted with Clover to provide covered services to members.

Provider Agreement: A signed agreement between Clover and a provider outlining the obligations of both parties in the delivery of quality care and covered services to members, and the compensation for those services.

Provider Manual: A document that explains Clover’s operating policies, standards, and procedures for participating providers including, but not limited to, Clover’s requirements for claims submission and payment, credentialing, utilization review, care management, quality improvement, advance directives, members’ rights, grievances, and appeals.

Quality Improvement Organization (QIO): An organization comprising practicing doctors and other healthcare experts under contract to the federal government to monitor and improve the care given to Medicare enrollees.

Representative: An individual appointed by an enrollee or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in an appeal or grievance.

Waste: Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Appendix A: Attachments

SAMPLE ID CARD

Clover

New Jersey Clover Health Choice Premier PPO (032)

Samantha A Greene

Member ID CPXXXXXX

Plan ID 80840

Start Date XX/XX/XXXX

RXPCN MEDDADV

RXBIN 004336

RXGRP RX8556

www.cloverhealth.com

CMS H5141-032

MedicareRx

Prescription Drug Coverage



Clover Member Services

888-778-1478 (TTY 711)

Copayment	In	Out
PCP Office Visit	\$0	\$0
ER Visit	\$120	\$120
Specialist Visit	\$15	\$15
Chiropractor	\$15	\$15

Medicare limiting charges apply.

Claims EDI# 77023

Clover Provider Services

877-853-8019

DentaQuest/EyeQuest

855-343-7404

Submit Claims (Medical)

Clover Health Claims

PO Box 3236

Scranton, PA 18505

CVS Caremark® Pharmacy

855-479-3657

Submit Claims (Pharmacy)

CVS Caremark

Part D Services

PO Box 52066

Phoenix, AZ 85072-2066

Clover Provider Manual

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APPENDIX A 85

Clover

Pre-Authorization Request

Need faster turnaround times?
Go online: cloverhealth.com/pre-auth



HOW TO USE THIS FORM:

- Complete** all required fields marked with an **asterisk (*)**.
Incomplete forms may be delayed unless all required information is received.
- Attach** copies of supporting clinical information.
Required clinical documentation is listed on our website: cloverhealth.com/pre-auth-list
- Fax** this form to 1-800-308-1107
- Call** us with questions, 1-888-995-1690 to chat with our Utilization Management dept.

MEMBER INFORMATION (please print clearly)

Member Name*	Member ID*	Date of Birth* ____/____/____ (MM / DD / YYYY)
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REQUESTING PROVIDER / FACILITY INFORMATION

Requesting NPI (Provider or Facility)* _____			Requesting Contact Name	
Requesting MD/Facility Name*			Title/Dept.	
Address*			Email	
City*	State*	ZIP code*	Phone	Fax

SERVICING PROVIDER / FACILITY INFORMATION

Servicing NPI (Provider or Facility)* _____		<input type="checkbox"/> Same as requesting Provider or Facility	Servicing Contact Name	
Servicing MD/Facility Name*		Specialty*	Title/Dept.	
Address*			Email	
City*	State*	ZIP code*	Phone	Fax

AUTHORIZATION REQUEST (please attach copies of required clinical documentation)*

Service Type* <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient		Place of Service* <input type="checkbox"/> MD Office <input type="checkbox"/> Home Health <input type="checkbox"/> DME <input type="checkbox"/> Amg Surg. <input type="checkbox"/> Other _____		Start Date or Admission Date* ____/____/____	End Date or Discharge Date ____/____/____
Primary Procedure Code (CPT/HCPCS)	Unit(s)	Modifier	Diagnosis Code (ICD 10)*	Service Description	
Additional Procedure Code(s) (CPT/HCPCS)	Unit(s)	Modifier	Diagnosis Code (ICD 10)	Service Description	

URGENT REQUEST (If applicable, explain medical need to expedite*)

Routine requests are processed on a 14 calendar day timeframe, but does not mean we will take the full 14 days as we will process according to the member's needs and no later than 72 hours if the physician documents that would place the member's health in danger.

Total
Pages:

Confidentiality Notice: This electronic fax transmission (including any documents, files or previous email messages attached to it) may contain confidential information that is intended for a specific individual and purpose and that is privileged or otherwise protected by law. If you are not the intended recipient, or a person responsible for delivering it to the intended recipient, a delete this fax and notify Clover UM of the error.

Clover Health

Provider Update Request

Email: providers@cloverhealth.com
Fax: Provider Services (908) 450 2059

Required Information: (please print clearly)	Contact person handling the requested change:
Provider Name:	Name:
Provider NPI: _ _ _ _ _	Phone #: (_ _ _) _ _ _ - _ _ _ _
Tax ID: _ _ - _ _ _ _ _	Fax #: (_ _ _) _ _ _ - _ _ _ _
Practice Name:	Email:

Adding Address:		
New primary address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Billing address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Office location? <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address:		Suite Number:
City:		State: Zip:
Phone:		Fax:
Email:		Effective Date of Change:

Changing Address: (use this field to update office contact information)		
Old Address		
Street Address:		
City:		State: Zip:
Phone:	Fax:	Email:

New Address:		
New primary address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Billing address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Office location? <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address:		Suite #:
City:		State: Zip:
Phone:		Fax:
Email:		Effective Date of Change:

Termination of Address Location:		
Street Address:		Suite #:
City:		State: Zip:
Phone:		Fax:
Email:		Effective Date of Change:

Signature:	Title:	Date:
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Clover Health

Provider Tax ID Update Form

*Required Attachment: W-9

Required Information: (please print clearly)		Contact person handling the requested change:	
Practice Name:		Name:	
Tax ID: ____ - ____ - ____ - ____ - ____		Phone #: (____) ____ - ____ - ____	
Is this Tax ID contracted with Clover? <input type="checkbox"/> Yes <input type="checkbox"/> No		Fax #: (____) ____ - ____ - ____	
Effective date:		Email:	

Provider Information: (Individuals only)	
Last Name:	
First Name:	
National Provider Identifier (NPI): ____ - ____ - ____ - ____ - ____ - ____	

Provider Information: (Groups only)	
Group Name:	Group NPI:
Does this update apply to all providers under this Tax ID? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please list all applicable NPIs below) *Attach separate roster if there are not enough fields to complete the form.	
Provider Name:	NPI: ____ - ____ - ____ - ____ - ____ - ____
Provider Name:	NPI: ____ - ____ - ____ - ____ - ____ - ____
Provider Name:	NPI: ____ - ____ - ____ - ____ - ____ - ____

Primary Office Address: (If more than one, attach a separate list of all office addresses)			
Street Address:		Suite #:	
City:		State:	Zip:
Phone:	Fax:	Email:	

Billing Address:			
Same as primary address? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Street Address:		Suite #:	
City:		State:	Zip:
Phone:	Fax:	Email:	

Signature:	Title:	Date:
------------	--------	-------

Request for Taxpayer Identification Number and Certification

► Go to www.irs.gov/FormW9 for instructions and the latest information.

**Give Form to the
requester. Do not
send to the IRS.**

Print or type.
See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC

☐ C Corporation

☐ S Corporation

☐ Partnership

☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ► _____

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

____ - ____ - _____

or

Employer identification number

____ - _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

**Sign
Here**

Signature of
U.S. person ►

Date ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.



Form for Requesting an Appeal of a Clover Health Denial

Because Clover Health (or one of our delegates) denied your request for coverage of (or payment for) medical benefits, you have the right to ask us for an appeal of our decision. You have 60 days from the date of our denial notice to ask us for an appeal. This form may be sent to us by mail or fax:

Clover Health
Attention: Appeals and Disputes
P.O. Box 471
Jersey City, NJ 07303
Fax: (732) 412-9706

Expedited appeal requests can be made by phone at 1-888-657-1207.

Speech and Hearing Impaired call 711.

Who May Make a Request: Your physician may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative (see information on how to add a representative below). Contact Customer Service at 1-888-657-1207 if you have any questions. TTY users should call 711. We are open 8 a.m. - 8 p.m. Local Time, 7 days a week. From April 1st through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

Member Information:		
Member Full Name:		
Member ID#:	Birth Date (MM/DD/YYYY): ____/____/____	Phone Number: (____) ____ - ____
Address:		
City:	State:	ZIP Code:
Complete the following section ONLY if the person making this request is not the member:		
Requestor's Name :		
Requestor's Relationship to Member:	Phone Number: (____) ____ - ____	
Address:		
City:	State:	ZIP Code:

Representation documentation for appeal requests made by someone other than member or the member's physician: If representation documentation was not submitted with the request for the organization determination, attach documentation showing the authority to represent the member (a completed Appointment of Representative (AOR) Form or other legal documentation that demonstrates representation per State law (e.g., a court appointed guardian, an individual who has Durable Power of Attorney, or a health care proxy, or a person designated under a health care consent statute). For more information on appointing a representative and how to obtain an AOR Form, please contact Customer Service at 1-888-657-1207. TTY users should call 711. You may also contact Medicare at 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

Important Note: Expedited Decisions:

If you or your physician believes that waiting 30 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your physician indicates that waiting 30 days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your physician's support for an expedited appeal, we will decide if your case requires a fast decision.

☐ CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS. If you have a supporting statement from your physician, attach it to this request.

Please explain your reasons for appealing. Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your physician and relevant medical records. You may want to refer to the explanation we provided in the denial notice you were issued.

Signature of person requesting the appeal (the member, or the member's physician or representative:
_____ **Date:** _____

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. This information is not a complete description of benefits. Call 1-888-778-1478 (TTY 711) for more information.

Clover Health

Request for Redetermination of Medicare Prescription Drug Denial

Because we, Clover Health, denied your request for coverage of (or payment for) a prescription drug, you have the right to ask us for a redetermination (appeal) of our decision. You have 60 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to ask us for a redetermination.

Send form by mail or fax:	Who may make a request: Your prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us to learn how to name a representative. Appeal through our website: www.cloverhealth.com Call for expedited appeal requests: (855) 479-3657
Address: CVS Caremark Part D MC109; P.O. Box 52000 Phoenix, AZ 85072-2000 Fax #: (855) 633-7673	

Enrollee's Information:		
Name:		
Street Address:		
City:	State:	Zipcode:
Phone Number: () -	Birth Date:	
Enrollee's Plan ID #:		

Complete the following section ONLY if the person making this request is not the enrollee:		
Requestor's name:		
Relationship to the Enrollee:		
Street Address:		
City:	State:	Zipcode:
Phone Number: () -		
Representation documentation for appeal requests made by someone other than enrollee or the enrollee's prescriber: Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination level. For more information on appointing a representative, contact your plan or 1-800-Medicare.		

Prescription drug you are requesting:		
Name of Drug:	Strength/quantity/dose:	
Have you purchased the drug pending appeal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If “yes”, please provide the following information:		
Date purchased:	Amount paid: \$ (attach copy of receipt)	
Pharmacy:	Pharmacy Telephone:	

Prescriber's Information:		
Name:		
Street Address:		
City:	State:	Zipcode:
Office Phone:	Fax:	
Office Contact Person:		

Important Note: Expedited Decisions
<p>If you or your prescriber believe that waiting seven days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting seven days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your prescriber's support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking us to pay you back for a drug you already received.</p> <p><input type="checkbox"/> CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION IN 72 HOURS</p>
<p>If you have a supporting statement from your prescriber, attach it to this request.</p> <p>Please explain your reasons for appealing. Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your prescriber and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medicare Prescription Drug Coverage.</p>

Signature of Person Requesting Appeal: (the enrollee, or the enrollee's prescriber or representative):	Date:
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New Jersey Department of Banking and Insurance

Health Care Provider Application to Appeal a Claims Determination

A Health Care Provider has the right to appeal a Carrier's claims determination(s).¹ A Health Care Provider also has the right to appeal an apparent lack of activity on a submitted claim.

Health Care Providers:

- Must submit your internal payment appeal to the Carrier. **DO NOT** submit your internal payment to the New Jersey Department of Banking and Insurance.
- May use either this form, or the Carrier's branded *Health Care Provider Application to Appeal a Claims Determination* (which the Carrier may allow to be submitted online). The Carrier will accept either form.

DO NOT submit a *Health Care Provider Application to Appeal a Claims Determination* IF:

- The Carrier's determination indicates that it considered the health care services for which the claim was submitted not medically necessary, experimental or investigational, cosmetic rather than medically necessary or dental rather than medical. **INSTEAD**, you may submit a request for a **Stage 1 UM Appeal Review**.²
- The Carrier's determination indicates that it considered the person to whom health care services for which the claim was submitted to be ineligible for coverage because the health care services were not covered under the terms of the relevant health benefits plan, or because the person is not the Carrier's member. **INSTEAD**, you may submit a complaint. For more information, contact the Carrier's Provider Relations Department.
- The Carrier has provided you with notice that it is investigating the claim (and related ones, if any) for possible fraud.

You MAY submit a *Health Care Provider Application to Appeal a Claims Determination* IF the Carrier's determination:

- Resulted in the claim not being paid at all for reasons other than a UM determination or a determination of ineligibility, coordination of benefits or fraud investigation
- Resulted in the claim being paid at a rate you did not expect based upon the payment agreement between you and the Carrier
- Resulted in the claim being paid at a rate you did not expect because of differences in the Carrier's treatment of the codes in the claim from what you believe is appropriate
- Indicated the Carrier required additional substantiating documentation to support the claim and you believe that the required information is inconsistent with the Carrier's stated claims handling policies and procedures, or is not relevant to the claim

You also MAY submit a *Health Care Provider Application to Appeal a Claims Determination* IF:

- You believe the Carrier failed to adjudicate the claim, or an uncontested portion of the claim, in a timely manner consistent with law, and the terms of the contract between you and the Carrier, if any
- The Carrier's determination indicates it will not pay because of lack of appropriate authorization, but you believe you obtained appropriate authorization from another Carrier for the services
- You believe the Carrier failed to appropriately pay interest on the claim
- You believe the Carrier's statement that it overpaid you on one or more claims is erroneous, or that the amount it calculated as overpaid is erroneous
- You believe the Carrier has attempted to offset an inappropriate amount against a claim because of an effort to recoup for an overpayment on prior claims (essentially, that the Carrier has under-priced the current claim)

If you do not know how to file a claims appeal with the Carrier, and you are a network provider, review your Provider Manual for instructions on how to file a Claims Appeal. If you are not a network provider, you can find general contact information [Licensed Insurance Carriers](#) or [Managed Care Entities](#) on our website. Contact the Carrier for more specific instructions.

¹ A carrier's contractors (organized delivery systems and other vendors) are subject to the same standards as the carrier when performing claim payment and processing functions (including overpayment requests) on behalf of the carrier. Use of the word Carrier includes the carrier and its relevant contractors.

² For more information: review your Provider Manual, or contact the Carrier's Utilization Management department or Provider Relations Department, or visit the New Jersey Department of Banking and Insurance's website at: [How to File a Utilization Management Appeal](#)

YOU MUST COMPLETE A SEPARATE APPLICATION FOR EACH CLAIM APPEALED SIGNATURE MUST BE COMPLETE AND LEGIBLE. THIS FORM MUST BE DATED.			
A. Provider Information	1. Provider Name:		2. TIN/NPI:
	3. Provider Group (if applicable):		
	4. Contact Name:		5. Title:
	6. Contact Address:		
	7. Phone:	8. Fax:	9. Email:
B. Patient Information	1. Patient Name:		2. Ins. ID:
	3. Did You Attach a copy of (check the appropriate response):		
	a. The assignment of benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA b. The Consent to Representation in Appeals of Utilization Management Determinations and Authorization to Release of Medical Records for UM Appeal and Arbitration of Claims? (Consent form is required for review of medical records if the matter goes to arbitration.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
C. Claim Information	1. Claim Number (if known):		2. Date of Service:
	3. Authorization Number:		
	4. Claim filing method (check only one):		
	a. <input type="checkbox"/> electronic (submit a copy of the electronic acceptance report from Our clearinghouse or Us) b. <input type="checkbox"/> facsimile (submit a copy of the fax transmittal) c. <input type="checkbox"/> paper claim by mail or courier service (submit a copy of the delivery confirmation evidence)		
	5. Check the reason(s) why you are filing this appeal (check all that apply and be specific about billing codes and reason for dispute): a. <input type="checkbox"/> Action has not been taken on this claim b. <input type="checkbox"/> Dispute of a denied claim → provide date of denial : ____ / ____ / ____ c. <input type="checkbox"/> Claim was paid but not in a timely manner (provide more information): <input type="checkbox"/> Yes <input type="checkbox"/> No Additional information was requested? If yes, date: ____ / ____ / ____ <input type="checkbox"/> Yes <input type="checkbox"/> No Additional information provided? If yes, date: ____ / ____ / ____ <input type="checkbox"/> Yes <input type="checkbox"/> No Prompt Payment Interest paid correctly? d. <input type="checkbox"/> Claim was paid, but the amount paid is in dispute: e. <input type="checkbox"/> Codes in dispute ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ f. <input type="checkbox"/> Dispute of an overpayment or the amount of overpayment (Attach a copy of overpayment request) g. <input type="checkbox"/> Dispute of carrier's offset amount against this claim (Attach a copy of A/R)		
D. Reason for Appeal (Required)			

Provider Name: _____

Contact Number: _____

Member Name : _____

DOS: _____

You may provide additional information in an attachment to explain why you are disputing Our handling of the claim. You must be specific about billing codes and reason for dispute.

The following should be submitted with your appeal (copies only):

- The relevant claim form
- The relevant Explanation(s) of Benefits or Remittance Advice
- A statement specifying the line items that you are appealing
- Copies of any overpayment requests or A/R notice
- Information We previously requested that you have not yet submitted, if available
- Itemization of your provider contract provisions you believe We are not complying with, including a copy of the pertinent section of your contract
- Pertinent correspondence between you and Us on this matter
- A description of pertinent communications between you and Us on this matter that were not in writing
- Relevant sections of the National Correct Coding Initiative (NCCI) or other coding support you relied upon IF the dispute concerns the disposition of billing codes
- Other documents you may believe support your position in this dispute (this may include medical records)

Attachments: ☐ Yes

☐ No

Signature: _____ Date: ____ / ____ / ____

Important to Note

In order to ensure your Internal Payment Appeal is eligible to meet processing requirements for the External Binding Arbitration Program

- **The Internal Appeal Form must be sent to the address posted on the carrier's website;**
- **The Internal Appeal Form must have a complete signature (first and last name);**
- **The Internal Appeal Form Must be Dated;**
- **There is a signed and dated Consent to Representation in Appeals of UM Determinations and Authorization for release of Medical records in UM Appeals and Independent Arbitration of Claims Form**

Appendix B: HEDIS and Clinical Guidelines for Providers

CLINICAL GUIDELINES

To review the latest Clover Clinical Guidelines for inpatient hospital stays and outpatient procedures for select conditions, visit the [Clover website](#).

HEDIS GUIDELINES

The Healthcare Effectiveness Data and Information Set (HEDIS) was created by the National Committee for Quality Assurance (NCQA) to measure the clinical quality performance of health plans.

The measures cover many aspects of healthcare, including preventive care like screenings (e.g., mammograms) and immunizations, management of physical and mental health conditions, access and availability of care, patient experience, utilization, and relative resource use.

Analysis of HEDIS data helps identify gaps in care, particularly preventive care, in populations as patients with diabetes mellitus, patients with cardiovascular disease, and patients with lung disease.

We know that providers are focused on delivering quality care that creates positive outcomes for our members. Please review the [HEDIS measures on the NCQA website](#) and adhere to these guidelines when managing your patients' care.

Appendix C: New Jersey

PCP RELATIONSHIP

When members enroll in our New Jersey plans, they are asked to tell us who their primary care provider is. If the member is not interested in establishing or maintaining care relationships within our network, they're less likely to be well served by the New Jersey plans.

We don't require a referral by a PCP to access care, but we do hope that the providers our members trust for their primary care will help them better understand how to access care within our network to maximize their plan benefits.

EXTRA HELP PROGRAMS

There are other resources, besides what's covered by the New Jersey plans, to reduce members' share of cost for prescription drugs. New Jersey has a number of State Pharmaceutical Assistance Programs (SPAP) programs with eligibility based on income and resources:

Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program

Beneficiaries pay \$5 generic copay or \$7 brand copay for covered medication during all phases of the Part D benefit.

ADAP

The AIDS Drug Assistance Program provides life-sustaining and life-prolonging medications to low-income individuals with no other source of payment for these drugs.

In 2019, Clover is offering the following plans in New Jersey

NJ CLOVER HEALTH CHOICE PPO (001)

Premiums and Benefits

- \$0 premium PPO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Same low copays in and out of network
- Available to Medicare-eligibles residing in Hudson County

PREMIUM/BENEFIT	MEMBER PAYS	PREMIUM/BENEFIT	MEMBER PAYS
Monthly Premium	\$0	Emergency Room	\$90 (waived if admitted)
Primary Care	\$0	Urgent Care	\$40 (waived if admitted)
Specialist Copays	\$25	Outpatient Surgery	Ambulatory: \$200 Hospital: \$290
Ambulance Copay	\$200	Inpatient Hospital	Days 1–6: \$290 Days 7–365: \$0
Lab Services Copay	\$10 (for Medicare-covered lab services)		
Diagnostic Copay Varies by place of service; see NaviNet or EOC for more details.	\$0–\$150		

NJ CLOVER HEALTH CHOICE PPO (001)

Part D Coverage—\$150 Deductible

INITIAL COVERAGE				COVERAGE GAP		CATASTROPHIC COVERAGE	
30-DAY SUPPLY				Upon reaching \$3,750–\$5,000 annual shared drug costs during the initial coverage phase, then member will be responsible for: 34% [†] Generic drugs 25% [†] Brand-name drugs		When a member’s annual out-of-pocket costs exceed \$5,000 the member pays: 5% or \$3.40 [‡] Generic/Preferred drugs 5% or \$8.50 [‡] All other drugs	
Preferred network		Standard network					
Tier 1	\$0	Tier 1	\$5				
Tier 2	\$10	Tier 2	\$15				
Tier 3	\$37*	Tier 3	\$47*				
Tier 4	\$85*	Tier 4	\$95*				
Tier 5	30%*	Tier 5	30%*				

*These tiers apply to the deductible.

[†]Coinsurance is not applicable to members who have Low-Income Subsidy.

[‡]Members pay whichever amount is greater; varies by drug.

NJ CLOVER HEALTH CHOICE PPO (004)

Premiums and Benefits

- \$0 premium PPO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Same low copays in and out of network
- Available to Medicare-eligibles residing in Atlantic, Bergen, Essex, Mercer, Monmouth, Morris, Passaic, Somerset, and Union Counties

PREMIUM/BENEFIT	MEMBER PAYS	PREMIUM/BENEFIT	MEMBER PAYS
Monthly Premium	\$0	Emergency Room	\$90 (waived if admitted)
Primary Care	\$0	Urgent Care	\$40 (waived if admitted)
Specialist Copays	\$25	Outpatient Surgery	Ambulatory: \$225 Hospital: \$325
Ambulance Copay	\$250	Inpatient Hospital	Days 1–6: \$290 Days 7–365: \$0
Lab Services Copay	\$10 (for Medicare-covered lab services)		
Diagnostic Copay Varies by place of service; see NaviNet or EOC for more details.	\$0–\$150		

NJ CLOVER HEALTH CHOICE PPO (004)

Part D Coverage—\$150 Deductible

INITIAL COVERAGE				COVERAGE GAP		CATASTROPHIC COVERAGE	
30-DAY SUPPLY				Upon reaching \$3,750–\$5,000 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs		When a member’s annual out-of-pocket costs exceed \$5,000 the member pays: 5% or \$3.40 [‡] Generic/Preferred drugs 5% or \$8.50 [‡] All other drugs	
Preferred network		Standard network					
Tier 1	\$0	Tier 1	\$5				
Tier 2	\$10	Tier 2	\$15				
Tier 3	\$47*	Tier 3	\$45*				
Tier 4	\$85*	Tier 4	\$95*				
Tier 5	30%*	Tier 5	30%*				

*These tiers apply to the deductible.

[†]Coinsurance is not applicable to members who have Low-Income Subsidy.

[‡]Members pay whichever amount is greater; varies by drug.

NJ CLOVER HEALTH CHOICE VALUE PPO (007)

Premiums and Benefits

- \$37.20 premium PPO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Same low copays in and out of network
- Available to Medicare-eligibles residing in Atlantic, Bergen, Essex, Hudson, Mercer, Monmouth, Morris, Passaic, Somerset, and Union Counties

PREMIUM/BENEFIT	MEMBER PAYS	PREMIUM/BENEFIT	MEMBER PAYS
Monthly Premium	\$37.20 (or less pending LIS eligibility)	Emergency Room	\$90 (waived if admitted)
Primary Care	\$0	Urgent Care Copay	\$40 (waived if admitted)
Specialist Copays	\$5		
Ambulance Copay	\$200	Outpatient Surgery	Ambulatory: \$100 Hospital: \$175
Lab Services Copay	\$0 (for Medicare-covered lab services)	Inpatient Hospital	Days 1–6: \$170 Days 7–365: \$0
Diagnostic Copay Varies by place of service; see NaviNet or EOC for more details.	\$0–\$150		

NJ CLOVER HEALTH CHOICE VALUE PPO (007)

Part D Coverage—\$415 Deductible

INITIAL COVERAGE				COVERAGE GAP	CATASTROPHIC COVERAGE
30-DAY SUPPLY				Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs	When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [‡] Generic/Other drugs that are treated like generic drugs 5% or \$8.50 [‡] All other drugs
Preferred network		Standard network			
Tier 1 \$0		Tier 1 \$10			
Tier 2	22%*	Tier 2	25%*		
Tier 3		Tier 3			
Tier 4	25%*	Tier 4			
Tier 5		Tier 5			

*These tiers apply to the deductible.

[†]Coinsurance is not applicable to members who have Low-Income Subsidy.

[‡]Members pay whichever amount is greater; varies by drug.

NJ CLOVER HEALTH CHOICE PREMIER PPO (032)

Premiums and Benefits

- \$75.70 premium PPO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Low copays for PCPs, specialists, and other services
- Same low copays in and out of network
- Available to members who reside in Burlington, Cumberland, Gloucester, Middlesex, Morris, and Ocean Counties

PREMIUM/BENEFIT	MEMBER PAYS	PREMIUM/BENEFIT	MEMBER PAYS
Monthly Premium	\$75.70 (or less pending LIS eligibility)	Emergency Room	\$120 (waived if admitted)
Primary Care	\$0	Urgent Care Copay	\$40 (waived if admitted)
Specialist Copays	\$15	Outpatient Surgery	Ambulatory: \$200 Hospital: \$200
Ambulance Copay	\$200	Inpatient Hospital	Days 1–6: \$275/day Days 7–365: \$0
Lab Services Copay	\$0 (for Medicare-covered lab services)		
Diagnostic Copay Varies by place of service; see NaviNet or EOC for more details.	\$0–\$150		

NJ CLOVER HEALTH CHOICE PREMIER PPO (032)

Part D Coverage—\$0 Deductible

INITIAL COVERAGE				COVERAGE GAP	CATASTROPHIC COVERAGE
30-DAY SUPPLY				Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs	When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [‡] Generic/Preferred drugs 5% or \$8.50 [‡] All other drugs
Preferred network		Standard network			
Tier 1	\$0	Tier 1	\$5		
Tier 2	\$8	Tier 2	\$13		
Tier 3	\$37*	Tier 3	\$47*		
Tier 4	\$85*	Tier 4	\$95*		
Tier 5	33%*	Tier 5	33%*		

*These tiers apply to the deductible.

[†]Coinsurance is not applicable to members who have Low-Income Subsidy.

[‡]Members pay whichever amount is greater; varies by drug.

NJ CLOVER HEALTH CHOICE PPO (041)

Premiums and Benefits

- \$0 premium PPO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Same low copays in and out of network
- Available to members who reside in Burlington, Camden, Cumberland, Gloucester, and Middlesex Counties

PREMIUM/BENEFIT	MEMBER PAYS	PREMIUM/BENEFIT	MEMBER PAYS
Monthly Premium	\$0 (or less pending LIS eligibility)	Emergency Room	\$90 (waived if admitted)
Primary Care	\$5	Urgent Care Copay	\$40 (waived if admitted)
Specialist Copays	\$35		
Ambulance Copay	\$250	Outpatient Surgery	Ambulatory: \$150 Hospital: \$200
Lab Services Copay	\$10 (for Medicare-covered lab services)	Inpatient Hospital	Days 1–6: \$350/day Days 7–365: \$0
Diagnostic Copay Varies by place of service; see NaviNet or EOC for more details.	\$0–\$150		

NJ CLOVER HEALTH CHOICE PPO (041)

Part D Coverage—\$0 Deductible

INITIAL COVERAGE				COVERAGE GAP	CATASTROPHIC COVERAGE
30-DAY SUPPLY				Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs	When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [‡] Generic/Preferred drugs 5% or \$8.50 [‡] All other drugs
Preferred network		Standard network			
Tier 1	\$0	Tier 1	\$5		
Tier 2	\$10	Tier 2	\$15		
Tier 3	\$37*	Tier 3	\$47*		
Tier 4	\$90*	Tier 4	\$100*		
Tier 5	33%*	Tier 5	33%*		

*These tiers apply to the deductible.

[†]Coinsurance is not applicable to members who have Low-Income Subsidy.

[‡]Members pay whichever amount is greater; varies by drug.

NJ CLOVER HEALTH CHOICE VALUE PPO (042)

Premiums and Benefits

- \$37.20 premium PPO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Same low copays in and out of network
- Available to members who reside in Burlington, Camden, Cumberland, and Gloucester Counties

PREMIUM/BENEFIT	MEMBER PAYS	PREMIUM/BENEFIT	MEMBER PAYS
Monthly Premium	\$37.20 (or less pending LIS eligibility)	Emergency Room	\$90 (waived if admitted)
Primary Care	\$5	Urgent Care Copay	\$40 (waived if admitted)
Specialist Copays	\$25		
Ambulance Copay	\$225	Outpatient Surgery	Ambulatory: \$150 Hospital: \$200
Lab Services Copay	\$5 (for Medicare-covered lab services)	Inpatient Hospital	Days 1–6: \$250 Days 7–365: \$0
Diagnostic Copay Varies by place of service; see NaviNet or EOC for more details.	\$0–\$150		

NJ CLOVER HEALTH CHOICE VALUE PPO (042)

Part D Coverage—\$415 Deductible

INITIAL COVERAGE				COVERAGE GAP	CATASTROPHIC COVERAGE
30-DAY SUPPLY				Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs	When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [‡] Generic/Other drugs that are treated like generic drugs 5% or \$8.50 [‡] All other drugs
Preferred network		Standard network			
Tier 1 \$0		Tier 1 \$12			
Tier 2	22%*	Tier 2	25%*		
Tier 3		Tier 3			
Tier 4	25%*	Tier 4			
Tier 5		Tier 5			

*These tiers apply to the deductible.

[†]Coinsurance is not applicable to members who have Low-Income Subsidy.

[‡]Members pay whichever amount is greater; varies by drug.

NJ CLOVER HEALTH CLASSIC HMO (002)

Premiums and Benefits

- \$0 premium HMO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Available to Medicare-eligibles residing in Atlantic, Bergen, Essex, Hudson, Passaic, and Union Counties

PREMIUM/BENEFIT	MEMBER PAYS	PREMIUM/BENEFIT	MEMBER PAYS
Monthly Premium	\$0	Emergency Room	\$90 (waived if admitted)
Primary Care	\$0	Urgent Care Copay	\$40 (waived if admitted)
Specialist Copays	\$25		
Ambulance Copay	\$250	Outpatient Surgery	Ambulatory: \$225 Hospital: \$325
Lab Services Copay	\$10 (for Medicare-covered lab services)	Inpatient Hospital	Days 1–6: \$290/day Days 7–365: \$0
Diagnostic Copay Varies by place of service; see NaviNet or EOC for more details.	\$0–\$150		

NJ CLOVER HEALTH CLASSIC HMO (002)

Part D Coverage—\$150 Deductible

INITIAL COVERAGE				COVERAGE GAP	CATASTROPHIC COVERAGE
30-DAY SUPPLY				Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs	When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [‡] Generic/Preferred drugs 5% or \$8.50 [‡] All other drugs
Preferred network		Standard network			
Tier 1	\$0	Tier 1	\$5		
Tier 2	\$10	Tier 2	\$15		
Tier 3	\$37*	Tier 3	\$47*		
Tier 4	\$85*	Tier 4	\$95*		
Tier 5	30%*	Tier 5	30%*		

*These tiers apply to the deductible.

[†]Coinsurance is not applicable to members who have Low-Income Subsidy.

[‡]Members pay whichever amount is greater; varies by drug.

NJ CLOVER HEALTH VALUE HMO (003)

Premiums and Benefits

- \$37.20 premium HMO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Available to Medicare-eligibles residing in Atlantic, Bergen, Essex, Hudson, Middlesex, Passaic, and Union Counties

PREMIUM/BENEFIT	MEMBER PAYS	PREMIUM/BENEFIT	MEMBER PAYS
Monthly Premium	\$37.20 (or less pending LIS eligibility)	Emergency Room	\$90 (waived if admitted)
Primary Care	\$0	Urgent Care Copay	\$40 (waived if admitted)
Specialist Copays	\$5		
Ambulance Copay	\$200	Outpatient Surgery	Ambulatory: \$100 Hospital: \$175
Lab Services Copay	\$0 (for Medicare-covered lab services)	Inpatient Hospital	Days 1–6: \$170 Days 7–365: \$0
Diagnostic Copay Varies by place of service; see NaviNet or EOC for more details.	\$0–\$150		

NJ CLOVER HEALTH VALUE HMO (003)

Part D Coverage—\$415 Deductible

INITIAL COVERAGE				COVERAGE GAP	CATASTROPHIC COVERAGE	
30-DAY SUPPLY				Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs	When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [†] Generic/Other drugs that are treated like generic drugs 5% or \$8.50 [†] All other drugs	
Preferred network		Standard network				
Tier 1	\$0	Tier 1	\$12			
Tier 2	22%*	Tier 2	25%*			
Tier 3		Tier 3				
	25%*	Tier 4				
		Tier 5				
Tier 4	25%*					
Tier 5						

*These tiers apply to the deductible.

[†]Coinsurance is not applicable to members who have Low-Income Subsidy.

*Members pay whichever amount is greater; varies by drug.

CASE MANAGEMENT PROGRAM

Clover's case management program supports members with multiple comorbidities, complex needs, and catastrophic, high-cost, high-risk conditions in their journey to wellness. Complex conditions and therapeutic areas include:

- HIV/AIDS
- Oncology
- Transplant
- Nonhealing wounds
- Multiple chronic conditions
- Other general complex conditions

TEAM-BASED CARE MANAGEMENT

Clover's Care Management Team is a multidisciplinary team composed of registered nurses, advanced practice registered nurses, licensed clinical social workers, clinical pharmacists, and medical directors who work with members, their families, their PCPs, and other physicians and healthcare professionals, as part of an interdisciplinary team to coordinate the most appropriate healthcare services. This team offers education about health conditions and the impact those conditions have on members' lives, assists in securing any authorizations in advance of services, and provides information on and coordination with community resources. Care management services are a combination of telephone and on-site services provided at the discretion of the Care Management Team. Care management is voluntary and free to all eligible members.

Members are identified as eligible for care management through:

- Health risk assessment
- Analysis of claims and encounter data
- Readmission reports
- UM data
- Pharmacy data
- Member and provider referrals

For additional information about the care management program, you can contact Provider Services at **1-877-853-8019** from 8:30 am–5 pm, local time, Monday–Friday.

You can also direct interested members to the Customer Experience line at **1-888-657-1207** from 8 am–8 pm local time, 7 days a week. Alternate technologies (for example, voicemail) will be used on the weekends, and holidays from February 15 through September 30.

Appendix D: Texas

NETWORK

Share of cost is an important factor in how patients access care. Our plan in Texas has a different share of cost for services and items that are administered outside of our network. Members have chosen this plan with the understanding that their share of cost is most favorable with an in-network provider. Where they must go out of network, Clover wants them to be able to make this choice intentionally with a full understanding of the costs associated.

Please consider the member's overall share of cost in addition to your professional judgment when referring members to providers that are out of the network; for example:

- Ancillary providers
- Durable medical equipment (DME)
- Labs

PCP RELATIONSHIP

We don't require a referral by a PCP to access care, but we do hope that the providers our members trust for their primary care will help them better understand how to access care within our network to maximize their plan benefits.

In 2019, Clover is offering the following plans in Texas

TX CLOVER HEALTH CHOICE PPO (025)

Premiums and Benefits

- \$0 premium PPO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Value of a PPO with low costs for PCPs, specialists, and hospital visits
- Partnership with the Baptist Integrated Physician Partners (BIPP) network
- Member must be a Bexar County resident to be eligible.

	In-Network	Out-of-Network
PREMIUM/BENEFIT	MEMBER PAYS	MEMBER PAYS
Monthly Premium	\$0	N/A
Primary Care Copay	\$0	35% coinsurance
Specialist Copay	\$35	
Ambulance Copay	\$250	\$250
Emergency Room	\$90 (waived if admitted)	\$90 (waived if admitted)
Urgent Care	\$40 (waived if admitted)	\$40 (waived if admitted)
Outpatient Surgery	Ambulatory: \$200 Hospital: \$250	35% coinsurance
Inpatient Hospital	Days 1–6: \$255/day Days 7–365: \$0/day	20% coinsurance
Lab Services	\$10 (for Medicare-covered lab services)	35% coinsurance
Diagnostics Varies by place of service; see NaviNet or EOC for more details.	\$0–\$150	35% coinsurance

TX CLOVER HEALTH CHOICE PPO (025)

Part D Coverage—\$0 Deductible

INITIAL COVERAGE				COVERAGE GAP	CATASTROPHIC COVERAGE
30-DAY SUPPLY				Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs	When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [‡] Generic/Preferred drugs 5% or \$8.50 [‡] All other drugs
Preferred network		Standard network			
Tier 1	\$3	Tier 1	\$8		
Tier 2	\$10	Tier 2	\$15		
Tier 3	\$37	Tier 3	\$47		
Tier 4	\$90	Tier 4	\$100		
Tier 5	33%	Tier 5	33%		

[†]Coinsurance is not applicable to members who have Low-Income Subsidy.

[‡]Members pay whichever amount is greater; varies by drug.

TX CLOVER HEALTH CLASSIC HMO (005)

Premiums and Benefits

- \$0 premium HMO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Available to Medicare-eligibles residing in Bexar County

PREMIUM/BENEFIT	MEMBER PAYS	PREMIUM/BENEFIT	MEMBER PAYS
Monthly Premium	\$0	Emergency Room	\$120 (waived if admitted)
Primary Care	\$0	Urgent Care Copay	\$30 (waived if admitted)
Specialist Copays	\$20		
Ambulance Copay	\$250	Outpatient Surgery	Ambulatory: \$150 Hospital: \$150
Lab Services Copay	\$0 (for Medicare-covered lab services)	Inpatient Hospital	Days 1–6: \$125 Days 7–365: \$0
Diagnostic Copay Varies by place of service; see NaviNet or EOC for more details.	\$0–\$150		

TX CLOVER HEALTH CLASSIC HMO (005)

Part D Coverage—\$0 Deductible

INITIAL COVERAGE				COVERAGE GAP	CATASTROPHIC COVERAGE
30-DAY SUPPLY				Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs	When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [‡] Generic/Preferred drugs 5% or \$8.50 [‡] All other drugs
Preferred network		Standard network			
Tier 1	\$0	Tier 1	\$5		
Tier 2	\$10	Tier 2	\$15		
Tier 3	\$37	Tier 3	\$47		
Tier 4	\$85	Tier 4	\$95		
Tier 5	33%	Tier 5	33%		

[†]Coinsurance is not applicable to members who have Low-Income Subsidy.

[‡]Members pay whichever amount is greater; varies by drug.

TX CLOVER HEALTH CLASSIC PLUS HMO (009)

Premiums and Benefits

- \$0 premium HMO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Available to Medicare-eligibles residing in Bexar County

PREMIUM/BENEFIT	MEMBER PAYS	PREMIUM/BENEFIT	MEMBER PAYS
Monthly Premium	\$0	Emergency Room	\$90 (waived if admitted)
Primary Care	\$25	Urgent Care Copay	\$40 (waived if admitted)
Specialist Copays	\$40		
Ambulance Copay	\$250	Outpatient Surgery	Ambulatory: \$300 Hospital: \$300
Lab Services Copay	\$15 (for Medicare-covered lab services)	Inpatient Hospital	Days 1–6: \$275 Days 7–365: \$0
Diagnostic Copay Varies by place of service; see NaviNet or EOC for more details.	\$0–\$150		

TX CLOVER HEALTH CLASSIC PLUS HMO (009)

Part D Coverage—\$415 Deductible

INITIAL COVERAGE		COVERAGE GAP	CATASTROPHIC COVERAGE
30-DAY SUPPLY		Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs	When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [‡] Generic/Preferred drugs 5% or \$8.50 [‡] All other drugs
CVS National Network			
Tier 1	25%*		
Tier 2	25%*		
Tier 3	25%*		
Tier 4	25%*		
Tier 5	25%*		

*These tiers apply to the deductible.

[†]Coinurance is not applicable to members who have Low-Income Subsidy.

[‡]Members pay whichever amount is greater; varies by drug.

TX CLOVER HEALTH CHOICE VALUE PPO (035)

Premiums and Benefits

- \$24 premium PPO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Value of a PPO with low costs for PCPs, specialists, and hospital visits
- Partnership with the Hospitals of Providence Physician Performance Network (HPPPN)
- Available to Medicare-eligibles residing in El Paso County

	In-Network	Out-of-Network
PREMIUM/BENEFIT	MEMBER PAYS	MEMBER PAYS
Monthly Premium	\$24	N/A
Primary Care Copay	\$0	35% coinsurance
Specialist Copay	\$20	
Ambulance Copay	\$200	\$200
Emergency Room	\$120 (waived if admitted)	\$120 (waived if admitted)
Urgent Care	\$40 (waived if admitted)	\$40 (waived if admitted)
Outpatient Surgery	Ambulatory: \$150 Hospital: \$150	35% coinsurance
Inpatient Hospital	Days 1–6: \$165/day Days 7–365: \$0/day	35% coinsurance
Lab Services	\$0 (for Medicare-covered lab services)	35% coinsurance
Diagnostics Varies by place of service; see NaviNet or EOC for more details.	\$0–\$100	35% coinsurance

TX CLOVER HEALTH CHOICE VALUE PPO (035)

Part D Coverage—\$415 Deductible

INITIAL COVERAGE				COVERAGE GAP		CATASTROPHIC COVERAGE	
30-DAY SUPPLY				Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs		When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [†] Generic/Other drugs that are treated like generic drugs 5% or \$8.50 [†] All other drugs	
Preferred network		Standard network					
Tier 1 \$0		Tier 1 \$12					
Tier 2 Tier 3 22%*		Tier 2 Tier 3 Tier 4 Tier 5 25%*					
Tier 4 Tier 5 25%*							

*These tiers apply to the deductible.

[†]Coinsurance is not applicable to members who have Low-Income Subsidy.

*Members pay whichever amount is greater; varies by drug.

TX CLOVER HEALTH CLASSIC HMO (008)

Premiums and Benefits

- \$0 premium HMO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Available to Medicare-eligibles residing in El Paso County

PREMIUM/BENEFIT	MEMBER PAYS	PREMIUM/BENEFIT	MEMBER PAYS
Monthly Premium	\$0	Emergency Room	\$120 (waived if admitted)
Primary Care	\$0	Urgent Care Copay	\$30 (waived if admitted)
Specialist Copays	\$30		
Ambulance Copay	\$200	Outpatient Surgery	Ambulatory: \$150 Hospital: \$150
Lab Services Copay	\$0 (for Medicare-covered lab services)	Inpatient Hospital	Days 1–6: \$200 Days 7–365: \$0
Diagnostic Copay Varies by place of service; see NaviNet or EOC for more details.	\$0–\$100		

TX CLOVER HEALTH CLASSIC HMO (005)

Part D Coverage—\$0 Deductible

INITIAL COVERAGE				COVERAGE GAP	CATASTROPHIC COVERAGE
30-DAY SUPPLY				Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs	When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [‡] Generic/Preferred drugs 5% or \$8.50 [‡] All other drugs
Preferred network		Standard network			
Tier 1	\$0	Tier 1	\$5		
Tier 2	\$10	Tier 2	\$15		
Tier 3	\$37	Tier 3	\$47		
Tier 4	\$85	Tier 4	\$95		
Tier 5	33%	Tier 5	33%		

[†]Coinsurance is not applicable to members who have Low-Income Subsidy.

[†]Members pay whichever amount is greater; varies by drug.

Appendix E: Georgia

NETWORK

Share of cost is an important factor in how patients access care. Members have chosen the Clover plan because they understand that their share of cost is most favorable with an in-network provider. Where they must go out of network, Clover Health wants them to be able to make this choice intentionally with a full understanding of the costs associated.

Please consider the member's overall share of cost in addition to your professional judgment when referring members to providers out-of-network; for example:

- Secondary providers
- Durable medical equipment (DME)
- Labs

PCP RELATIONSHIP

We don't require a referral by a PCP to access care, but we do hope that the providers our members trust for their primary care will help them better understand how to access care within our network to maximize their plan benefits.

In 2019, Clover Health is offering the following plans in Georgia

GA CLOVER HEALTH CHOICE PPO (026)

Premiums and Benefits

- \$0 premium PPO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Value of a PPO with low costs
- [SmartSenior](#) membership for health screenings and education
- Available to Medicare-eligibles residing in Chatham County

	In-Network	Out-of-Network
PREMIUM/BENEFIT	MEMBER PAYS	MEMBER PAYS
Monthly Premium	\$0	N/A
Primary Care Copay	\$0	30% coinsurance
Specialist Copay	\$25	
Inpatient Hospital	Days 1–6: \$270/day Days 7–365: \$0/day	20% coinsurance
Outpatient Service/Surgery	Ambulatory: \$275 Hospital: \$275	30% coinsurance
Ambulance Copay	\$220	\$220
Emergency Room	\$90 (waived if admitted)	\$90 (waived if admitted)
Urgent Care	\$25 (waived if admitted)	\$25 (waived if admitted)
Lab Services	\$0 (for Medicare-covered lab services)	30% coinsurance
Diagnostics Varies by place of service; see NavinNet or EOC for more details.	\$0–\$200	30% coinsurance

GA CLOVER HEALTH CHOICE PPO (026)

Part D Coverage—\$0 Deductible

INITIAL COVERAGE				COVERAGE GAP		CATASTROPHIC COVERAGE	
30-DAY SUPPLY				Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs		When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [‡] Generic/Preferred drugs 5% or \$8.50 [‡] All other drugs	
Preferred network		Standard network					
Tier 1	\$0	Tier 1	\$5				
Tier 2	\$10	Tier 2	\$15				
Tier 3	\$37	Tier 3	\$47				
Tier 4	\$90	Tier 4	\$100				
Tier 5	33%	Tier 5	33%				

[†]Coinsurance is not applicable to members who have Low Income Subsidy.

[‡]Members pay whichever amount is greater; varies by drug.

GA CLOVER HEALTH CHOICE PLUS PPO (043)

Premiums and Benefits

- \$0 premium PPO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Value of a PPO with low costs for PCPs, specialists, and hospital visits
- Available to Medicare-eligibles residing in Chatham County

	In-Network	Out-of-Network
PREMIUM/BENEFIT	MEMBER PAYS	MEMBER PAYS
Monthly Premium	\$0	N/A
Primary Care Copay	\$5	50% coinsurance
Specialist Copay	\$36	
Inpatient Hospital	Days 1–6: \$265/day Days 7–365: \$0/day	20% coinsurance
Outpatient Service/Surgery	Ambulatory: \$300 Hospital: \$300	50% coinsurance
Ambulance Copay	\$250	\$250
Emergency Room	\$90 (waived if admitted)	\$90 (waived if admitted)
Urgent Care	\$50 (waived if admitted)	\$50 (waived if admitted)
Lab Services	\$10 (for Medicare-covered lab services)	50% coinsurance
Diagnostics Varies by place of service; see NavinNet or EOC for more details.	\$0–\$200	50% coinsurance

GA CLOVER HEALTH CHOICE PLUS PPO (043)

Part D Coverage—\$415 Deductible

INITIAL COVERAGE		COVERAGE GAP	CATASTROPHIC COVERAGE
30-DAY SUPPLY		Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs	When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [‡] Generic/Preferred drugs 5% or \$8.50 [‡] All other drugs
CVS National Network			
Tier 1	25%*		
Tier 2	25%*		
Tier 3	25%*		
Tier 4	25%*		
Tier 5	25%*		

*These tiers apply to the deductible.

[†]Coinsurance is not applicable to members who have Low-Income Subsidy.

[‡]Members pay whichever amount is greater; varies by drug.

Appendix F: Pennsylvania

NETWORK

Share of cost is an important factor in how patients access care. Members have chosen the Clover plan with the understanding that their share of cost is most favorable with an in-network provider. Where they must go out of network, Clover wants them to be able to make this choice intentionally with a full understanding of the costs associated.

Please consider the member's overall share of cost in addition to your professional judgment when referring members to out-of-network providers; for example:

- Secondary providers
- Durable medical equipment (DME)
- Labs

PCP RELATIONSHIP

We don't require a referral by a PCP to access care, but we do hope that the providers our members trust for their primary care will help them better understand how to access care within our network to maximize their plan benefits.

EXTRA HELP PROGRAMS

There are other resources to reduce members' share of cost for prescription drugs. Pennsylvania has a number of SPAPs with eligibility based on income and resources:

Program of All-inclusive Care for the Elderly (PACE)

Beneficiaries pay \$6 generic copay or \$9 brand copay for covered medication during all phases of the Part D benefit.

PACENET

Beneficiaries pay \$8 generic copay or \$15 brand copay for covered medication during all phases of the Part D benefit.

Special Pharmaceutical Benefits Program (SPBP) - HIV/AIDS

Provides pharmaceutical assistance and specific lab services to low- to moderate-income individuals living with a diagnosis of HIV/AIDS who are not eligible for pharmacy services under the Medical Assistance (MA) Program.

SPBP Mental Health

Provides service to individuals with schizophrenia who do not respond to first-line drug therapies and who are not eligible for pharmaceutical coverage under the MA Program.

In 2019, Clover Health is offering the following plans in Pennsylvania

PA CLOVER HEALTH CHOICE PPO (038)

Premiums and Benefits

- \$0 premium PPO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Value of a PPO with low costs
- Available to Medicare-eligibles residing in Philadelphia and Bucks Counties

	In-Network	Out-of-Network
PREMIUM/BENEFIT	MEMBER PAYS	MEMBER PAYS
Monthly Premium	\$0	N/A
Primary Care Copay	\$5	30% coinsurance
Specialist Copay	\$40	
Inpatient Hospital	Days 1–6: \$300/day Days 7–365: \$0	25% coinsurance
Outpatient Service/Surgery	Ambulatory: \$175 Hospital: \$225	30% coinsurance
Ambulance Copay	\$200	\$200
Emergency Room	\$120 (waived if admitted)	\$120 (waived if admitted)
Urgent Care	\$45 (waived if admitted)	\$45 (waived if admitted)
Lab Services	\$0 (for Medicare-covered services)	30% coinsurance
Diagnostics Varies by place of service; see NaviNet or EOC for more details.	\$0–\$150	

PA CLOVER HEALTH CHOICE PPO (038)

Part D Coverage—\$0 Deductible

INITIAL COVERAGE				COVERAGE GAP		CATASTROPHIC COVERAGE	
30-DAY SUPPLY				Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs		When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [‡] Generic/Preferred drugs 5% or \$8.50 [‡] All other drugs	
Preferred network		Standard network					
Tier 1	\$2	Tier 1	\$7				
Tier 2	\$12	Tier 2	\$17				
Tier 3	\$37	Tier 3	\$47				
Tier 4	\$90	Tier 4	\$100				
Tier 5	33%*	Tier 5	33%*				

*These tiers apply to the deductible.

†Coinsurance is not applicable to members who have Low Income Subsidy.

*Members pay whichever amount is greater; varies by drug.

PA CLOVER HEALTH CHOICE VALUE PPO (039)

Premiums and Benefits

- \$37 premium PPO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Value of a PPO with low costs
- Members who qualify for Extra Help (e.g., LIS, PACE, or PACENET) can have their prescription drugs subsidized at a lower cost-share
- Available to Medicare-eligibles residing in Philadelphia and Bucks Counties

	In-Network	Out-of-Network
PREMIUM/BENEFIT	MEMBER PAYS	MEMBER PAYS
Monthly Premium	\$37	N/A
Primary Care Copay	\$0	30% coinsurance
Specialist Copay	\$40	
Inpatient Hospital	Days 1–6: \$250/day Days 7–365: \$0	30% coinsurance
Outpatient Service/Surgery	Ambulatory: \$175 Hospital: \$225	30% coinsurance
Ambulance Copay	\$190	\$190
Emergency Room	\$100 (waived if admitted)	\$100 (waived if admitted)
Urgent Care	\$45 (waived if admitted)	\$45 (waived if admitted)
Lab Services	\$0 (for Medicare-covered services)	30% coinsurance
Diagnostics Varies by place of service; see NaviNet or EOC for more details.	\$0–\$150	30% coinsurance

PA CLOVER HEALTH CHOICE VALUE PPO (039)

Part D Coverage—\$415 Deductible

INITIAL COVERAGE				COVERAGE GAP	CATASTROPHIC COVERAGE
30-DAY SUPPLY				Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs	When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [‡] Generic/Other drugs that are treated like generic drugs 5% or \$8.50 [‡] All other drugs
Preferred network		Standard network			
Tier 1 \$0		Tier 1 \$12			
Tier 2	22%*	Tier 2	25%*		
Tier 3		Tier 3			
Tier 4	25%*	Tier 4			
Tier 5		Tier 5			

*These tiers apply to the deductible.

[†]Coinsurance is not applicable to members who have Low-Income Subsidy.

[‡]Members pay whichever amount is greater; varies by drug.

Appendix G: South Carolina

NETWORK

Share of cost is an important factor in how patients access care. Members have chosen the Clover plan with the understanding that their share of cost is most favorable with an in-network provider. Where they must go out of network, Clover wants them to be able to make this choice intentionally with a full understanding of the costs associated.

Please consider the member's overall share of cost in addition to your professional judgment when referring members to out-of-network providers; for example:

- Secondary providers
- Durable medical equipment (DME)
- Labs

PCP RELATIONSHIP

We don't require a referral by a PCP to access care, but we do hope that the providers our members trust for their primary care will help them better understand how to access care within our network to maximize their plan benefits.

In 2019, Clover is offering the following plans in South Carolina

SC CLOVER HEALTH CHOICE PPO (036)

Premiums and Benefits

- \$0 premium PPO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Value of a PPO with low costs for PCPs, specialists, and hospital visits
- Available to Medicare-eligibles residing in Charleston County

	In-Network	Out-of-Network
PREMIUM/BENEFIT	MEMBER PAYS	MEMBER PAYS
Monthly Premium	\$0	N/A
Primary Care Copay	\$0	35% coinsurance
Specialist Copay	\$35	
Inpatient Hospital	Days 1–6: \$310/day Days 7–365: \$0	Days 1–6: \$310/day Days 7–365: \$0
Outpatient Service/Surgery	Ambulatory: \$225 Hospital: \$275	35% coinsurance
Ambulance Copay	\$250	\$250
Emergency Room	\$90 (waived if admitted)	\$90 (waived if admitted)
Urgent Care	\$40 (waived if admitted)	\$40 (waived if admitted)
Lab Services	\$0 (for Medicare-covered services)	35% coinsurance
Diagnostics Varies by place of service; see NaviNet or EOC for more details.	\$0–\$150	35% coinsurance

SC CLOVER HEALTH CHOICE PPO (036)

Part D Coverage—\$0 Deductible

INITIAL COVERAGE				COVERAGE GAP	CATASTROPHIC COVERAGE
30-DAY SUPPLY				Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs	When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [‡] Generic/Preferred drugs 5% or \$8.50 [‡] All other drugs
Preferred network		Standard network			
Tier 1	\$0	Tier 1	\$5		
Tier 2	\$10	Tier 2	\$15		
Tier 3	\$37	Tier 3	\$47		
Tier 4	\$90	Tier 4	\$100		
Tier 5	33%*	Tier 5	33%*		

*These tiers apply to the deductible.

[†]Coinsurance is not applicable to members who have Low Income Subsidy.

[‡]Members pay whichever amount is greater; varies by drug.

SC CLOVER HEALTH CHOICE VALUE PPO (037)

Premiums and Benefits

- \$24.60 premium PPO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Value of a PPO with low costs for PCPs, specialists, and hospital visits
- Available to Medicare-eligibles residing in Charleston County

	In-Network	Out-of-Network
PREMIUM/BENEFIT	MEMBER PAYS	MEMBER PAYS
Monthly Premium	\$24.60	N/A
Primary Care Copay	\$0	35% coinsurance
Specialist Copay	\$25	
Inpatient Hospital	Days 1–6: \$300/day Days 7–365: \$0	Days 1–6: \$300/day Days 7–365: \$0
Outpatient Service/Surgery	Ambulatory: \$225 Hospital: \$275	35% coinsurance
Ambulance Copay	\$200	\$200
Emergency Room	\$90 (waived if admitted)	\$90 (waived if admitted)
Urgent Care	\$40 (waived if admitted)	\$40 (waived if admitted)
Lab Services	\$0 (for Medicare-covered services)	35% coinsurance
Diagnostics Varies by place of service; see NaviNet or EOC for more details.	\$0–\$150	35% coinsurance

SC CLOVER HEALTH CHOICE VALUE PPO (037)

Part D Coverage—\$415 Deductible

INITIAL COVERAGE				COVERAGE GAP		CATASTROPHIC COVERAGE	
30-DAY SUPPLY				Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs		When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [†] Generic/Other drugs that are treated like generic drugs 5% or \$8.50 [†] All other drugs	
Preferred network		Standard network					
Tier 1 \$0		Tier 1 \$12					
Tier 2 22%*		Tier 2 25%*					
Tier 3 22%*		Tier 3 25%*					
Tier 4 25%*		Tier 4 25%*					
Tier 5 25%*		Tier 5 25%*					

*These tiers apply to the deductible.

[†]Coinsurance is not applicable to members who have Low-Income Subsidy.

*Members pay whichever amount is greater; varies by drug.

Appendix H: Tennessee

NETWORK

Share of cost is an important factor in how patients access care. Members have chosen the Clover plan with the understanding that their share of cost is most favorable with an in-network provider. Where they must go out of network, Clover wants them to be able to make this choice intentionally with a full understanding of the costs associated.

Please consider the member's overall share of cost in addition to your professional judgment when referring members to out-of-network providers; for example:

- Secondary providers
- Durable medical equipment (DME)
- Labs

PCP RELATIONSHIP

We don't require a referral by a PCP to access care, but we do hope that the providers our members trust for their primary care will help them better understand how to access care within our network to maximize their plan benefits.

In 2019, Clover is offering the following plans in Tennessee

TN CLOVER HEALTH CHOICE PPO (033)

Premiums and Benefits

- \$0 premium PPO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Value of a PPO with low costs for PCPs, specialists, and hospital visits
- Partnership with the Ascension Care Management provider network
- Available to Medicare-eligibles residing in Davidson, Rutherford, and Williamson Counties

	In-Network	Out-of-Network
PREMIUM/BENEFIT	MEMBER PAYS	MEMBER PAYS
Monthly Premium	\$0	N/A
Primary Care Copay	\$0	35% coinsurance
Specialist Copay	\$40	
Inpatient Hospital	Days 1–6: \$275/day Days 7–365: \$0	20% coinsurance
Outpatient Service/Surgery	Ambulatory: \$325 Hospital: \$325	35% coinsurance
Ambulance Copay	\$250	\$250
Emergency Room	\$90 (waived if admitted)	\$90 (waived if admitted)
Urgent Care	\$45 (waived if admitted)	\$45 (waived if admitted)
Lab Services	\$5 (for Medicare-covered services)	35% coinsurance
Diagnostics Varies by place of service; see NaviNet or EOC for more details.	\$0–\$150	35% coinsurance

TN CLOVER HEALTH CHOICE PPO (033)

Part D Coverage—\$100 Deductible

INITIAL COVERAGE				COVERAGE GAP		CATASTROPHIC COVERAGE	
30-DAY SUPPLY				Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs		When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [‡] Generic/Preferred drugs 5% or \$8.50 [‡] All other drugs	
Preferred network		Standard network					
Tier 1	\$2	Tier 1	\$7				
Tier 2	\$12	Tier 2	\$17				
Tier 3	\$37	Tier 3	\$47				
Tier 4	\$90	Tier 4	\$100				
Tier 5	31%*	Tier 5	31%*				

*These tiers apply to the deductible.
[†]Coinsurance is not applicable to members who have Low Income Subsidy.
[‡]Members pay whichever amount is greater; varies by drug.

TN CLOVER HEALTH CHOICE VALUE PPO (034)

Premiums and Benefits

- \$31.40 premium PPO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Value of a PPO with low costs for PCPs, specialists, and hospital visits
- Available to Medicare-eligibles residing in Davidson, Rutherford, and Williamson Counties

	In-Network	Out-of-Network
PREMIUM/BENEFIT	MEMBER PAYS	MEMBER PAYS
Monthly Premium	\$31.40	N/A
Primary Care Copay	\$0	35% coinsurance
Specialist Copay	\$20	
Inpatient Hospital	Days 1–6: \$225/day Days 7–365: \$0	25% coinsurance
Outpatient Service/Surgery	Ambulatory: \$200 Hospital: \$250	35% coinsurance
Ambulance Copay	\$225	\$225
Emergency Room	\$90 (waived if admitted)	\$90 (waived if admitted)
Urgent Care	\$40 (waived if admitted)	\$40 (waived if admitted)
Lab Services	\$0 (for Medicare-covered services)	35% coinsurance
Diagnostics Varies by place of service; see NaviNet or EOC for more details.	\$0–\$150	35% coinsurance

TN CLOVER HEALTH CHOICE VALUE PPO (034)

Part D Coverage—\$415 Deductible

INITIAL COVERAGE				COVERAGE GAP	CATASTROPHIC COVERAGE
30-DAY SUPPLY				Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs	When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [†] Generic/Other drugs that are treated like generic drugs 5% or \$8.50 [†] All other drugs
Preferred network		Standard network			
Tier 1	\$0	Tier 1	\$12		
Tier 2	22%*	Tier 2	25%*		
Tier 3		Tier 3			
Tier 4	25%*	Tier 4			
Tier 5		Tier 5			

*These tiers apply to the deductible.
[†]Coinsurance is not applicable to members who have Low-Income Subsidy.
*Members pay whichever amount is greater; varies by drug.

Appendix I: Arizona

In 2019, Clover is offering the following plan in Arizona

AZ CLOVER HEALTH CHOICE PPO (040)

Premiums and Benefits

- \$0 premium PPO Medicare Advantage plan with Part D coverage
- \$0 Part C deductible
- Value of a PPO with low costs for PCPs, specialists, and hospital visits
- Available to Medicare-eligibles residing in Pima County

	In-Network	Out-of-Network
PREMIUM/BENEFIT	MEMBER PAYS	MEMBER PAYS
Monthly Premium	\$0	N/A
Primary Care Copay	\$0	35% coinsurance
Specialist Copay	\$25	
Inpatient Hospital	Days 1–6: \$250/day Days 7–365: \$0	25% coinsurance
Outpatient Service/Surgery	Ambulatory: \$200 Hospital: \$200	35% coinsurance
Ambulance Copay	\$220	\$220
Emergency Room	\$120 (waived if admitted)	\$120 (waived if admitted)
Urgent Care	\$25 (waived if admitted)	\$25 (waived if admitted)
Lab Services	\$2 (for Medicare-covered services)	35% coinsurance
Diagnostics Varies by place of service; see NaviNet or EOC for more details.	\$0–\$150	35% coinsurance

AZ CLOVER HEALTH CHOICE PPO (040)

Part D Coverage—\$0 Deductible

INITIAL COVERAGE				COVERAGE GAP		CATASTROPHIC COVERAGE	
30-DAY SUPPLY				Upon reaching \$3,820–\$5,100 annual shared drug costs during the initial coverage phase, then member will be responsible for: 37% [†] Generic drugs 25% [†] Brand-name drugs		When a member’s annual out-of-pocket costs exceed \$5,100 the member pays: 5% or \$3.40 [‡] Generic/Preferred drugs 5% or \$8.50 [‡] All other drugs	
Preferred network		Standard network					
Tier 1	\$0	Tier 1	\$5				
Tier 2	\$7	Tier 2	\$12				
Tier 3	\$37	Tier 3	\$47				
Tier 4	\$90	Tier 4	\$100				
Tier 5	33%*	Tier 5	33%*				

*These tiers apply to the deductible.

†Coinsurance is not applicable to members who have Low Income Subsidy.

*Members pay whichever amount is greater; varies by drug.