New Jersey—2018 Medical Benefits

Effective Date: 1/1/2018 | Version 1.0

Medical Benefit Description	CarePoint Green Plan 001	Classic Aqua Plan 004	Premier Orange Plan 007	NJ Purple Plan 032
Part D Deductible For **Part D Copay** information, see pages 31–32.	**$150**/year for Part D prescription drugs Tiers 1 and 2 are not subject to the deductible.	**$150**/year for Part D prescription drugs Tiers 1 and 2 are not subject to the deductible.	**$405**/year for Part D prescription drugs Tier 1 is not subject to the deductible.	**$150**/year for Part D prescription drugs Tiers 1 and 2 are not subject to the deductible.
Out-of-Pocket Max	**$6,700**/year Does not include prescription drugs or supplemental benefits.	**$6,700**/year Does not include prescription drugs or supplemental benefits.	**$6,700**/year Does not include prescription drugs or supplemental benefits.	**$6,700**/year Does not include prescription drugs or supplemental benefits.
Counties	Hudson	Atlantic, Bergen, Essex, Mercer, Monmouth, Passaic, Somerset, Union	Atlantic, Bergen, Essex, Hudson, Mercer, Monmouth, Passaic, Somerset, Union	Burlington, Cumberland, Gloucester, Morris, Middlesex, Ocean
INPATIENT CARE				
Inpatient Hospital Care Includes Substance Abuse and Rehabilitation Services *May require prior authorization	**$290** copay/day Days 1–6 **$0** copay/day Days 7–365 Copay applies per stay.	**$290** copay/day Days 1–6 **$0** copay/day Days 7–365 Copay applies per stay.	**$170** copay/day Days 1–6 **$0** copay/day Days 7–365 Copay applies per stay.	**$290** copay/day Days 1–6 **$0** copay/day Days 7–365 Copay applies per stay.
Inpatient Mental Health Care *May require prior authorization	**$260** copay/day Days 1–6 **$0** copay/day Days 7–365 Copay applies per stay.	**$260** copay/day Days 1–6 **$0** copay/day Days 7–365 Copay applies per stay.	**$130** copay/day Days 1–6 **$0** copay/day Days 7–365 Copay applies per stay.	**$260** copay/day Days 1–6 **$0** copay/day Days 7–365 Copay applies per stay.

Coinsurance will always be taken on applicable services in addition to the copay.

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INPATIENT CARE *(continued)*				
Skilled Nursing Facility In a Medicare-certified skilled nursing facility *May require prior authorization	**$0** copay/day Days 1–20 **$160** copay/day Days 21–100 No prior hospital stay is required. Member is covered for 100 days/benefit period.	**$0** copay/day Days 1–20 **$160** copay/day Days 21–100 No prior hospital stay is required. Member is covered for 100 days/benefit period.	**$0** copay/day Days 1–20 **$160** copay/day Days 21–100 No prior hospital stay is required. Member is covered for 100 days/benefit period.	**$0** copay/day Days 1–20 **$160** copay/day Days 21–100 No prior hospital stay is required. Member is covered for 100 days/benefit period.
Hospice	Member must receive care from a Medicare-certified Hospice. When enrolled in a hospice program, hospice services and Part A and Part B services related to the terminal prognosis are paid for by Original Medicare, not Clover Health. Clover Health will pay for a consultative visit before selecting a hospice.	Member must receive care from a Medicare-certified Hospice. When enrolled in a hospice program, hospice services and Part A and Part B services related to the terminal prognosis are paid for by Original Medicare, not Clover Health. Clover Health will pay for a consultative visit before selecting a hospice.	Member must receive care from a Medicare-certified Hospice. When enrolled in a hospice program, hospice services and Part A and Part B services related to the terminal prognosis are paid for by Original Medicare, not Clover Health. Clover Health will pay for a consultative visit before selecting a hospice.	Member must receive care from a Medicare-certified Hospice. When enrolled in a hospice program, hospice services and Part A and Part B services related to the terminal prognosis are paid for by Original Medicare, not Clover Health. Clover Health will pay for a consultative visit before selecting a hospice.

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OUTPATIENT CARE				
Physician Services Including doctor office visits for illness/injury	**$0** for each primary care office visit and Outpatient Medical Procedures by a PCP **$25** for each specialist office visit and Outpatient Medical Procedures by a Specialist **Clover recognized PCPs:** Family Practice, General Practice, Internal Medicine, OB-GYN, Geriatric Medicine. Copay is taken on facility claim, not the professional claim, if applicable.	**$0** for each primary care office visit and Outpatient Medical Procedures by a PCP **$25** for each specialist office visit and Outpatient Medical Procedures by a Specialist **Clover recognized PCPs:** Family Practice, General Practice, Internal Medicine, OB-GYN, Geriatric Medicine. Copay is taken on facility claim, not the professional claim, if applicable.	**$0** for each primary care office visit and Outpatient Medical Procedures by a PCP **$5** or each specialist office visit and Outpatient Medical Procedures by a Specialist **Clover recognized PCPs:** Family Practice, General Practice, Internal Medicine, OB-GYN, Geriatric Medicine. Copay is taken on facility claim, not the professional claim, if applicable.	**$10** for each primary care office visit and Outpatient Medical Procedures by a PCP **$25** for each specialist office visit and Outpatient Medical Procedures by a Specialist **Clover recognized PCPs:** Family Practice, General Practice, Internal Medicine, OB-GYN, Geriatric Medicine. Copay is taken on facility claim, not the professional claim, if applicable.
Home Health Care Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc. *May require prior authorization	**$0** for all Medicare covered home health visits and home therapy sessions	**$0** for all Medicare covered home health visits and home therapy sessions	**$0** for all Medicare covered home health visits and home therapy sessions	**$0** for all Medicare covered home health visits and home therapy sessions

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OUTPATIENT CARE *(continued)*				
Chiropractic Services	**$20** for each Medicare covered chiropractic service (manual manipulation of the spine to correct subluxation). Limit to 30 visits/year. No coverage for routine chiropractic services.	**$20** for each Medicare covered chiropractic service (manual manipulation of the spine to correct subluxation). Limit to 30 visits/year. No coverage for routine chiropractic services.	**$10** for each Medicare covered chiropractic service (manual manipulation of the spine to correct subluxation). Limit to 30 visits/year. No coverage for routine chiropractic services.	**$20** for each Medicare covered chiropractic service (manual manipulation of the spine to correct subluxation). Limit to 30 visits/year. No coverage for routine chiropractic services.
Podiatry Services	**$25** for each Medicare covered podiatry visit and podiatry surgery No coverage for routine podiatry services.	**$25** for each Medicare covered podiatry visit and podiatry surgery No coverage for routine podiatry services.	**$5** for each Medicare covered podiatry visit and podiatry surgery No coverage for routine podiatry services.	**$25** for each Medicare covered podiatry visit and podiatry surgery No coverage for routine podiatry services.

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OUTPATIENT CARE *(continued)*				
Outpatient Rehabilitation Services *May require prior authorization	**$25** for each Medicare covered Physical Therapy session Limit to $2,010 per year combined with Speech Therapy. **$25** for each Medicare covered Occupational Therapy session Limit to $2,010 per year. **$25** for each Medicare covered Speech/Language Therapy session Limit to $2,010 per year combined with Physical Therapy. **$25** for each Medicare covered Cardiac Rehab session, Intensive Cardiac Rehab service, Pulmonary Rehab session, and for other Medicare covered therapy sessions **Cardiac Rehab:** Limit to 36 sessions per year. **Intensive Cardiac Rehab:** Limit to 72 sessions per year. **Pulmonary Rehab:** Limit to 36 sessions per year.	**$25** for each Medicare covered Physical Therapy session Limit to $2,010 per year combined with Speech Therapy. **$25** for each Medicare covered Occupational Therapy session Limit to $2,010 per year. **$25** for each Medicare covered Speech/Language Therapy session Limit to $2,010 per year combined with Physical Therapy. **$25** for each Medicare covered Cardiac Rehab session, Intensive Cardiac Rehab service, Pulmonary Rehab session, and for other Medicare covered therapy sessions **Cardiac Rehab:** Limit to 36 sessions per year. **Intensive Cardiac Rehab:** Limit to 72 sessions per year. **Pulmonary Rehab:** Limit to 36 sessions per year.	**$10** for each Medicare covered Physical Therapy session Limit to $2,010 per year combined with Speech Therapy. **$10** for each Medicare covered Occupational Therapy session Limit to $2,010 per year. **$10** for each Medicare covered Speech/Language Therapy session Limit to $2,010 per year combined with Physical Therapy. **$10** for each Medicare covered Cardiac Rehab session, Intensive Cardiac Rehab service, Pulmonary Rehab session, and for other Medicare covered therapy sessions **Cardiac Rehab:** Limit to 36 sessions per year. **Intensive Cardiac Rehab:** Limit to 72 sessions per year. **Pulmonary Rehab:** Limit to 36 sessions per year.	**$25** for each Medicare covered Physical Therapy session Limit to $2,010 per year combined with Speech Therapy. **$25** for each Medicare covered Occupational Therapy session Limit to $2,010 per year. **$25** for each Medicare covered Speech/Language Therapy session Limit to $2,010 per year combined with Physical Therapy. **$25** for each Medicare covered Cardiac Rehab session, Intensive Cardiac Rehab service, Pulmonary Rehab session, and for other Medicare covered therapy sessions **Cardiac Rehab:** Limit to 36 sessions per year. **Intensive Cardiac Rehab:** Limit to 72 sessions per year. **Pulmonary Rehab:** Limit to 36 sessions per year.

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OUTPATIENT CARE *(continued)*				
Outpatient Mental Health Including Partial Hospitalization *May require prior authorization	**$25** for each Medicare covered individual therapy visit, group therapy visit, and mental health services **$25** for each Medicare covered individual therapy visit with a psychiatrist, group therapy visit with a psychiatrist, and mental health services with a psychiatrist **$25** per day for Medicare covered partial hospitalization program services	**$25** may apply for each Medicare covered individual therapy visit, group therapy visit, and mental health services **$25** may apply for each Medicare covered individual therapy visit with a psychiatrist, group therapy visit with a psychia-trist, and mental health services with a psychiatrist **$25** per day for Medicare covered partial hospitalization program services	**$5** may apply for each Medicare covered individual therapy visit, group therapy visit, and mental health services **$5** may apply for each Medicare covered individual therapy visit with a psychiatrist, group therapy visit with a psychia-trist, and mental health services with a psychiatrist **$5** per day for Medicare covered partial hospitalization program services	**$25** may apply for each Medicare covered individual therapy visit, group therapy visit, and mental health services **$25** may apply for each Medicare covered individual therapy visit with a psychiatrist, group therapy visit with a psychia-trist, and mental health services with a psychiatrist **$25** per day for Medicare covered partial hospitalization program services
Outpatient Observation	**$0** if admitted to inpatient from observation; inpatient R&B copay will apply **$90** if admitted to observation through ER **$290** if observation leads to surgery **$90** if discharged home from observation	**$0** if admitted to inpatient from observation; inpatient R&B copay will apply **$90** if admitted to observation through ER **$325** if observation leads to surgery **$90** if discharged home from observation	**$0** if admitted to inpatient from observation; inpatient R&B copay will apply **$90** if admitted to observation through ER **$175** if observation leads to surgery **$90** if discharged home from observation	**$0** if admitted to inpatient from observation; inpatient R&B copay will apply **$90** if admitted to observation through ER **$325** if observation leads to surgery **$90** if discharged home from observation

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OUTPATIENT CARE *(continued)*				
Outpatient Substance Abuse Care *May require prior authorization	**$25** for each Medicare covered substance abuse service (with or without a psychiatrist)	**$25** for each Medicare covered substance abuse service (with or without a psychiatrist)	**$5** for each Medicare covered substance abuse service (with or without a psychiatrist)	**$25** for each Medicare covered substance abuse service (with or without a psychiatrist)
Ambulatory Surgery *May require prior authorization	**$200** for each Medicare covered visit to an ambulatory surgical center	**$225** for each Medicare covered visit to an ambulatory surgical center	**$100** for each Medicare covered visit to an ambulatory surgical center	**$225** for each Medicare covered visit to an ambulatory surgical center
Outpatient Surgery & Supplies *May require prior authorization	**$290** for each Medicare covered visit to an outpatient hospital facility **$0** for each Medicare covered visit in an office setting by a PCP, except for diagnostic colonoscopy (see Diagnostic Colonoscopy category) **$25** for each Medicare covered visit in an office setting by a Specialist, except for diagnostic colonoscopy (see Diagnostic Colonoscopy category)	**$325** for each Medicare covered visit to an outpatient hospital facility **$0** for each Medicare covered visit in an office setting by a PCP, except for diagnostic colonoscopy (see Diagnostic Colonoscopy category) **$25** for each Medicare covered visit in an office setting by a Specialist, except for diagnostic colonoscopy (see Diagnostic Colonoscopy category)	**$175** for each Medicare covered visit to an outpatient hospital facility **$0** for each Medicare covered visit in an office setting by a PCP, except for diagnostic colonoscopy (see Diagnostic Colonoscopy category) **$5** for each Medicare covered visit in an office setting by a Specialist, except for diagnostic colonoscopy (see Diagnostic Colonoscopy category)	**$325** for each Medicare covered visit to an outpatient hospital facility **$10** for each Medicare covered visit in an office setting by a PCP, except for diagnostic colonoscopy (see Diagnostic Colonoscopy category) **$25** for each Medicare covered visit in an office setting by a Specialist, except for diagnostic colonoscopy (see Diagnostic Colonoscopy category)
Anesthesia	**$0** for each Medicare covered anesthesia service	**$0** for each Medicare covered anesthesia service	**$0** for each Medicare covered anesthesia service	**$0** for each Medicare covered anesthesia service

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OUTPATIENT CARE *(continued)*				
Ambulance Services Medically necessary ambulance services *May require prior authorization	**$200**/one-way trip for Medicare covered ambulance transports Copay will not be waived if admitted to the hospital.	**$250**/one-way trip for Medicare covered ambulance transports Copay will not be waived if admitted to the hospital.	**$200**/one-way trip for Medicare covered ambulance transports Copay will not be waived if admitted to the hospital.	**$250**/one-way trip for Medicare covered ambulance transports Copay will not be waived if admitted to the hospital.
Emergency Care Member may go to any emergency room.	**$75** for each visit to an Emergency Room **$0** for emergency room visit if admitted to the hospital Plan does not offer World Wide Coverage.	**$75** for each visit to an Emergency Room **$0** for emergency room visit if admitted to the hospital Plan does not offer World Wide Coverage.	**$75** for each visit to an Emergency Room **$0** for emergency room visit if admitted to the hospital Plan does not offer World Wide Coverage.	**$75** for each visit to an Emergency Room **$0** for emergency room visit if admitted to the hospital Plan does not offer World Wide Coverage.
Urgently Needed Care This is NOT emergency care.	**$40** of the cost for Medicare covered Urgent Needed Care Visit **$0** for urgently needed care visit if admitted to the hospital	**$40** of the cost for Medicare covered Urgent Needed Care Visit **$0** for urgently needed care visit if admitted to the hospital	**$40** of the cost for Medicare covered Urgent Needed Care Visit **$0** for urgently needed care visit if admitted to the hospital	**$40** of the cost for Medicare covered Urgent Needed Care Visit **$0** for urgently needed care visit if admitted to the hospital
Durable Medical Equipment (DME) & Supplies Includes wheelchairs, oxygen, etc. *May require prior authorization	**20%** of the cost for each Medicare covered item	**20%** of the cost for each Medicare covered item	**20%** of the cost for each Medicare covered item	**20%** of the cost for each Medicare covered item

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OUTPATIENT CARE *(continued)*				
Prosthetic & Orthotic Devices Includes braces, artificial limbs and eyes, etc. *May require prior authorization	**20%** of the cost for each Medicare covered prosthetic device or orthotic device	**20%** of the cost for each Medicare covered prosthetic device or orthotic device	**20%** of the cost for each Medicare covered prosthetic device or orthotic device	**20%** of the cost for each Medicare covered prosthetic device or orthotic device
Diabetes Self-Monitoring Training and Supplies Includes coverage for glucose monitors, test strips, lancets, screening tests, and self management training	**$0** for Medicare covered Diabetes self-management training, Medicare covered Diabetes monitoring supplies, and Medicare covered Therapeutic shoes or inserts **Initial Year:** up to 10 hours of self-management training within a continuous 12-month period **Subsequent Year:** up to 2 hours of self-management training each year after the initial year Limit to 1 pair of diabetic shoes per year. Limit to 3 pairs of diabetic shoe inserts per year.	**$0** for Medicare covered Diabetes self-management training, Medicare covered Diabetes monitoring supplies, and Medicare covered Therapeutic shoes or inserts **Initial Year:** up to 10 hours of self-management training within a continuous 12-month period **Subsequent Year:** up to 2 hours of self-management training each year after the initial year Limit to 1 pair of diabetic shoes per year. Limit to 3 pairs of diabetic shoe inserts per year.	**$0** for Medicare covered Diabetes self-management training, Medicare covered Diabetes monitoring supplies, and Medicare covered Therapeutic shoes or inserts **Initial Year:** up to 10 hours of self-management training within a continuous 12-month period **Subsequent Year:** up to 2 hours of self-management training each year after the initial year Limit to 1 pair of diabetic shoes per year. Limit to 3 pairs of diabetic shoe inserts per year.	**$0** for Medicare covered Diabetes self-management training, Medicare covered Diabetes monitoring supplies, and Medicare covered Therapeutic shoes or inserts **Initial Year:** up to 10 hours of self-management training within a continuous 12-month period **Subsequent Year:** up to 2 hours of self-management training each year after the initial year Limit to 1 pair of diabetic shoes per year. Limit to 3 pairs of diabetic shoe inserts per year.

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OUTPATIENT CARE *(continued)*				
If a member receives multiple diagnostic tests and therapeutic services (e.g. labs, X-rays, and radiation) at the same location on the same day, only the maximum cost share applies.				
Clinical/Diagnostic Labs *May require prior authorization	**Up to $10** for Medicare-covered clinical/ diagnostic lab or pathology service **$0** for venipuncture, transportation, and set up of lab equipment	**Up to $10** for Medicare-covered clinical/ diagnostic lab or pathology service **$0** for venipuncture, transportation, and set up of lab equipment	**Up to $10** for Medicare-covered clinical/ diagnostic lab or pathology service **$0** for venipuncture, transportation, and set up of lab equipment	**Up to $10** for Medicare-covered clinical/ diagnostic lab or pathology service **$0** for venipuncture, transportation, and set up of lab equipment
Radiation Therapy *May require prior authorization	**Up to $30** for each radiation therapy service	**Up to $30** for each radiation therapy service	**Up to $30** for each radiation therapy service	**Up to $30** for each radiation therapy service
Radiology/X-Rays	**Up to $30** for each General Radiology/ X-ray service **$0** for the transportation & set up of X-Ray equipment	**Up to $30** for each General Radiology/ X-ray service **$0** for the transportation & set up of X-Ray equipment	**Up to $30** for each General Radiology/ X-ray service **$0** for the transportation & set up of X-Ray equipment	**Up to $30** for each General Radiology/ X-ray service **$0** for the transportation & set up of X-Ray equipment
Advanced Radiology Including MRA, MRI, Nuclear Med, PET scans, & CAT Scans *May require prior authorization	**Up to $150** for Advanced Radiology services in an outpatient setting **Up to $30** for Advanced Radiology services in an office setting Limit to 1 per lifetime for PET Beta Amyloid Dementia and Neurodegenerative Disease.	**Up to $150** for Advanced Radiology services in an outpatient setting **Up to $30** for Advanced Radiology services in an office setting Limit to 1 per lifetime for PET Beta Amyloid Dementia and Neurodegenerative Disease.	**Up to $150** for Advanced Radiology services in an outpatient setting **Up to $30** for Advanced Radiology services in an office setting Limit to 1 per lifetime for PET Beta Amyloid Dementia and Neurodegenerative Disease.	**Up to $150** for Advanced Radiology services in an outpatient setting **Up to $30** for Advanced Radiology services in an office setting Limit to 1 per lifetime for PET Beta Amyloid Dementia and Neurodegenerative Disease.

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OUTPATIENT CARE *(continued)*				
If a member receives multiple diagnostic tests and therapeutic services (e.g. labs, X-rays, and radiation) at the same location on the same day, only the maximum cost share applies.				
Diagnostic Tests—Allergy	**Up to $10** for Allergy services (includes testing and treatment) from a PCP or specialist	**Up to $10** for Allergy services (includes testing and treatment) from a PCP or specialist	**Up to $10** for Allergy services (includes testing and treatment) from a PCP or specialist	**Up to $10** for Allergy services (includes testing and treatment) from a PCP or specialist
Diagnostic Tests—Cardiology *May require prior authorization	**Up to $150** for each Cardiology service in an outpatient setting **Up to $30** for each Cardiology service in an office setting	**Up to $150** for each Cardiology service in an outpatient setting **Up to $30** for each Cardiology service in an office setting	**Up to $150** for each Cardiology service in an outpatient setting **Up to $30** for each Cardiology service in an office setting	**Up to $150** for each Cardiology service in an outpatient setting **Up to $30** for each Cardiology service in an office setting
Diagnostic Tests—Echo *May require prior authorization	**Up to $150** for each Echography service in an outpatient setting **Up to $30** for each Echography service in an office setting	**Up to $150** for each Echography service in an outpatient setting **Up to $30** for each Echography service in an office setting	**Up to $150** for each Echography service in an outpatient setting **Up to $30** for each Echography service in an office setting	**Up to $150** for each Echography service in an outpatient setting **Up to $30** for each Echography service in an office setting
Diagnostic Tests—EEG *May require prior authorization	**Up to $150** for each EEG service in an outpatient setting **Up to $30** for each EEG service in an office setting	**Up to $150** for each EEG service in an outpatient setting **Up to $30** for each EEG service in an office setting	**Up to $150** for each EEG service in an outpatient setting **Up to $30** for each EEG service in an office setting	**Up to $150** for each EEG service in an outpatient setting **Up to $30** for each EEG service in an office setting
Diagnostic Tests—EKG	**$0** for each EKG service	**$0** for each EKG service	**$0** for each EKG service	**$0** for each EKG service

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OUTPATIENT CARE *(continued)*				
If a member receives multiple diagnostic tests and therapeutic services (e.g. labs, X-rays, and radiation) at the same location on the same day, only the maximum cost share applies.				
Diagnostic Tests—Gastroenterology *May require prior authorization	**Up to $150** for each Gastroenterology service in an outpatient setting **Up to $30** for each Gastroenterology service in an office setting	**Up to $150** for each Gastroenterology service in an outpatient setting **Up to $30** for each Gastroenterology service in an office setting	**Up to $150** for each Gastroenterology service in an outpatient setting **Up to $30** for each Gastroenterology service in an office setting	**Up to $150** for each Gastroenterology service in an outpatient setting **Up to $30** for each Gastroenterology service in an office setting
Diagnostic Tests—Other Diagnostic Services *May require prior authorization	**Up to $150** for each Diagnostic service in an outpatient setting **Up to $30** for each Diagnostic service in an office setting	**Up to $150** for each Diagnostic service in an outpatient setting **Up to $30** for each Diagnostic service in an office setting	**Up to $150** for each Diagnostic service in an outpatient setting **Up to $30** for each Diagnostic service in an office setting	**Up to $150** for each Diagnostic service in an outpatient setting **Up to $30** for each Diagnostic service in an office setting
Diagnostic Tests—Pulmonary *May require prior authorization	**Up to $150** for each Pulmonary service in an outpatient setting **Up to $30** for each Pulmonary service in an office setting	**Up to $150** for each Pulmonary service in an outpatient setting **Up to $30** for each Pulmonary service in an office setting	**Up to $150** for each Pulmonary service in an outpatient setting **Up to $30** for each Pulmonary service in an office setting	**Up to $150** for each Pulmonary service in an outpatient setting **Up to $30** for each Pulmonary service in an office setting

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OUTPATIENT CARE *(continued)*				
If a member receives multiple diagnostic tests and therapeutic services (e.g. labs, X-rays, and radiation) at the same location on the same day, only the maximum cost share applies.				
Diagnostic Tests—Sleep Study *May require prior authorization	**Up to $150** for each Sleep Study service in an outpatient setting **Up to $30** for each Sleep Study service in an office setting	**Up to $150** for each Sleep Study service in an outpatient setting **Up to $30** for each Sleep Study service in an office setting	**Up to $150** for each Sleep Study service in an outpatient setting **Up to $30** for each Sleep Study service in an office setting	**Up to $150** for each Sleep Study service in an outpatient setting **Up to $30** for each Sleep Study service in an office setting
Diagnostic Tests—Ultrasound	**Up to $150** for each Ultrasound service in an outpatient setting **Up to $30** for each Ultrasound service in an office setting	**Up to $150** for each Ultrasound service in an outpatient setting **Up to $30** for each Ultrasound service in an office setting	**Up to $150** for each Ultrasound service in an outpatient setting **Up to $30** for each Ultrasound service in an office setting	**Up to $150** for each Ultrasound service in an outpatient setting **Up to $30** for each Ultrasound service in an office setting
Diagnostic Tests—Vascular *May require prior authorization	**Up to $150** for each Vascular service in an outpatient setting **Up to $30** for each Vascular service in an office setting	**Up to $150** for each Vascular service in an outpatient setting **Up to $30** for each Vascular service in an office setting	**Up to $150** for each Vascular service in an outpatient setting **Up to $30** for each Vascular service in an office setting	**Up to $150** for each Vascular service in an outpatient setting **Up to $30** for each Vascular service in an office setting

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OUTPATIENT CARE *(continued)*				
If a member receives multiple diagnostic tests and therapeutic services (e.g. labs, X-rays, and radiation) at the same location on the same day, only the maximum cost share applies.				
Diagnostic Colonoscopy *May require prior authorization	**Up to $290** for each Diagnostic Colonoscopy in an outpatient setting **Up to $200** for each Diagnostic Colonoscopy in an office or ASC setting	**Up to $325** for each Diagnostic Colonoscopy in an outpatient setting **Up to $225** for each Diagnostic Colonoscopy in an office or ASC setting	**Up to $175** for each Diagnostic Colonoscopy in an outpatient setting **Up to $100** for each Diagnostic Colonoscopy in an office or ASC setting	**Up to $325** for each Diagnostic Colonoscopy in an outpatient setting **Up to $225** for each Diagnostic Colonoscopy in an office or ASC setting
Diagnostic Bone Mass Measurement	**Up to $150** for each Medicare covered Diagnostic Bone Mass Measurement in an outpatient setting **Up to $30** for each Medicare covered Diagnostic Bone Mass Measurement in an office setting	**Up to $150** for each Medicare covered Diagnostic Bone Mass Measurement in an outpatient setting **Up to $30** for each Medicare covered Diagnostic Bone Mass Measurement in an office setting	**Up to $150** for each Medicare covered Diagnostic Bone Mass Measurement in an outpatient setting **Up to $30** for each Medicare covered Diagnostic Bone Mass Measurement in an office setting	**Up to $150** for each Medicare covered Diagnostic Bone Mass Measurement in an outpatient setting **Up to $30** for each Medicare covered Diagnostic Bone Mass Measurement in an office setting
Diagnostic Mammogram	**Up to $150** for each Medicare covered Diagnostic Mammgoram in an outpatient setting **Up to $30** for each Medicare covered Diagnostic Mammogram in an office setting	**Up to $150** for each Medicare covered Diagnostic Mammgoram in an outpatient setting Up to **$30** for each Medicare covered Diagnostic Mammogram in an office setting	**Up to $150** for each Medicare covered Diagnostic Mammgoram in an outpatient setting **Up to $30** for each Medicare covered Diagnostic Mammogram in an office setting	**Up to $150** for each Medicare covered Diagnostic Mammgoram in an outpatient setting **Up to $30** for each Medicare covered Diagnostic Mammogram in an office setting

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OUTPATIENT CARE (continued)				
Chemotherapy *May require prior authorization	**20%** of the cost for each chemo-therapy service, chemotherapy drug, and Oncology Service	**20%** of the cost for each chemo-therapy service, chemotherapy drug, and Oncology Service	**20%** of the cost for each chemo-therapy service, chemotherapy drug, and Oncology Service	**20%** of the cost for each chemo-therapy service, chemotherapy drug, and Oncology Service
Surgical Supplies, Splints, and Casts *May require prior authorization	**20%** of the cost for surgical supplies, dressings, splints & casts	**20%** of the cost for surgical supplies, dressings, splints & casts	**20%** of the cost for surgical supplies, dressings, splints & casts	**20%** of the cost for surgical supplies, dressings, splints & casts
Blood	Coverage for blood, storage, and administration begins w/ the 1st pint of blood. **$0** per unit of blood for Medicare covered benefits	Coverage for blood, storage, and administration begins w/ the 1st pint of blood. **$0** per unit of blood for Medicare covered benefits	Coverage for blood, storage, and administration begins w/ the 1st pint of blood. **$0** per unit of blood for Medicare covered benefits	Coverage for blood, storage, and administration begins w/ the 1st pint of blood. **$0** per unit of blood for Medicare covered benefits
Outpatient Part B Drugs & Injectables Covered under Medicare Part B *May require prior authorization	**20%** of the cost for outpatient Part B Drugs & Injectables, Infusion Therapy, Nebulizer Drugs, and Imaging Agents Limit of 1 per month for B-12 injection. Limit of 1 per lifetime for PET Beta Amyloid Dementia and Neurodegenerative Disease. Limit of 3 per lifetime for Autogous Cellar Immuntherapy.	**20%** of the cost for outpatient Part B Drugs & Injectables, Infusion Therapy, Nebulizer Drugs, and Imaging Agents Limit of 1 per month for B-12 injection. Limit of 1 per lifetime for PET Beta Amyloid Dementia and Neurodegenerative Disease. Limit of 3 per lifetime for Autogous Cellar Immuntherapy.	**20%** of the cost for outpatient Part B Drugs & Injectables, Infusion Therapy, Nebulizer Drugs, and Imaging Agents Limit of 1 per month for B-12 injection. Limit of 1 per lifetime for PET Beta Amyloid Dementia and Neurodegenerative Disease. Limit of 3 per lifetime for Autogous Cellar Immuntherapy.	**20%** of the cost for outpatient Part B Drugs & Injectables, Infusion Therapy, Nebulizer Drugs, and Imaging Agents Limit of 1 per month for B-12 injection. Limit of 1 per lifetime for PET Beta Amyloid Dementia and Neurodegenerative Disease. Limit of 3 per lifetime for Autogous Cellar Immuntherapy.

New Jersey—2018 Medical Benefits

Medical Benefit Description	CarePoint Green Plan 001	Classic Aqua Plan 004	Premier Orange Plan 007	NJ Purple Plan 032
OUTPATIENT CARE *(continued)*				
Renal Dialysis	**20%** of the cost for Medicare Covered renal dialysis **$0** for Medicare Covered kidney disease education services **20%** of the cost for outpatient dialysis services Limit to includes 6 sessions (individual or group) per lifetime for Kidney Disease Education.	**20%** of the cost for Medicare Covered renal dialysis **$0** for Medicare Covered kidney disease education services **20%** of the cost for outpatient dialysis services Limit to includes 6 sessions (individual or group) per lifetime for Kidney Disease Education.	**20%** of the cost for Medicare Covered renal dialysis **$0** for Medicare Covered kidney disease education services **20%** of the cost for outpatient dialysis services Limit to 6 sessions (individual or group) per lifetime for Kidney Disease Education.	**20%** of the cost for Medicare Covered renal dialysis **$0** for Medicare Covered kidney disease education services **20%** of the cost for outpatient dialysis services Limit to 6 sessions (individual or group) per lifetime for Kidney Disease Education.

New Jersey—2018 Medical Benefits

Medical Benefit Description	CarePoint Green Plan 001	Classic Aqua Plan 004	Premier Orange Plan 007	NJ Purple Plan 032
PREVENTIVE SERVICES				
Abdominal Aortic Aneurysm (AAA) Screening	**$0** for each Abdominal Aortic Aneurysm (AAA) screening Limit to 1 per lifetime.	**$0** for each Abdominal Aortic Aneurysm (AAA) screening Limit to 1 per lifetime.	**$0** for each Abdominal Aortic Aneurysm (AAA) screening Limit to 1 per lifetime.	**$0** for each Abdominal Aortic Aneurysm (AAA) screening Limit to 1 per lifetime.
Alcohol Misuse Screening and Counseling	**$0** for each alcohol misuse screening/counseling service Limit to 1 per year for misuse screening, 15 min. Limit to 4 times per year for brief face-to-face counseling, 15 min.	**$0** for each alcohol misuse screening/counseling service Limit to 1 per year for misuse screening, 15 min. Limit to 4 times per year for brief face-to-face counseling, 15 min.	**$0** for each alcohol misuse screening/counseling service Limit to 1 per year for misuse screening, 15 min. Limit to 4 times per year for brief face-to-face counseling, 15 min.	**$0** for each alcohol misuse screening/counseling service Limit to 1 per year for misuse screening, 15 min. Limit to 4 times per year for brief face-to-face counseling, 15 min.
Annual Wellness Visit (AWV) This is not the IPPE	**$0** for the annual wellness visit	**$0** for the annual wellness visit	**$0** for the annual wellness visit	**$0** for the annual wellness visit
Bone Mass Measurement Screening	**$0** for each Medicare covered Preventive Bone Mass Measurement Limit to 1 every 24 months.	**$0** for each Medicare covered Preventive Bone Mass Measurement Limit to 1 every 24 months.	**$0** for each Medicare covered Preventive Bone Mass Measurement Limit to 1 every 24 months.	**$0** for each Medicare covered Preventive Bone Mass Measurement Limit to 1 every 24 months.
Cardiovascular Screening Blood Tests	**$0** for each Medicare covered cardiovascular disease screening test Limit to 1 every 5 years.	**$0** for each Medicare covered cardiovascular disease screening test Limit to 1 every 5 years.	**$0** for each Medicare covered cardiovascular disease screening test Limit to 1 every 5 years.	**$0** for each Medicare covered cardiovascular disease screening test Limit to 1 every 5 years.

Coinsurance will always be taken on applicable services in addition to the copay.

Medical Benefit Description	CarePoint Green Plan 001	Classic Aqua Plan 004	Premier Orange Plan 007	NJ Purple Plan 032
PREVENTIVE SERVICES *(continued)*				
Colorectal Cancer Screening Exams For people with Medicare age 50 and older & others at high risk regardless of age. Outpatient Surgery copay will apply if there is a surgical procedure during a screening colonoscopy.	**$0** for each Fecal Occult blood test Limit 1 per year. **$0** for each Flexible Sigmoidoscopy Limit to 1 every 4 years. (If a screening colonoscopy has been performed, Clover may cover a screening flexible sigmoid-oscopy only after 10 years.) **$0** for each Screening Colonoscopy Limit to 1 every 24 months at high risk. Limit to 1 every 10 years not at high risk. (For any risk, if a screening flexible sigmoidoscopy has been performed Clover may cover a screening colonoscopy only after 4 years.) **$0** for each Barium Enema Limit to 1 every 24 months at high risk. Limit to 1 every 4 years not at high risk. **$0** for each Colorectal Cancer Screening with Cologuard Limit to 1 per 3 years.	**$0** for each Fecal Occult blood test Limit 1 per year. **$0** for each Flexible Sigmoidoscopy Limit to 1 every 4 years. (If a screening colonoscopy has been performed, Clover may cover a screening flexible sigmoid-oscopy only after 10 years.) **$0** for each Screening Colonoscopy Limit to 1 every 24 months at high risk. Limit to 1 every 10 years not at high risk. (For any risk, if a screening flexible sigmoidoscopy has been performed Clover may cover a screening colonoscopy only after 4 years.) **$0** for each Barium Enema Limit to 1 every 24 months at high risk. Limit to 1 every 4 years not at high risk. **$0** for each Colorectal Cancer Screening with Cologuard Limit to 1 per 3 years.	**$0** for each Fecal Occult blood test Limit 1 per year. **$0** for each Flexible Sigmoidoscopy Limit to 1 every 4 years. (If a screening colonoscopy has been performed, Clover may cover a screening flexible sigmoid-oscopy only after 10 years.) **$0** for each Screening Colonoscopy Limit to 1 every 24 months at high risk. Limit to 1 every 10 years not at high risk. (For any risk, if a screening flexible sigmoidoscopy has been performed Clover may cover a screening colonoscopy only after 4 years.) **$0** for each Barium Enema Limit to 1 every 24 months at high risk. Limit to 1 every 4 years not at high risk. **$0** for each Colorectal Cancer Screening with Cologuard Limit to 1 per 3 years.	**$0** for each Fecal Occult blood test Limit 1 per year. **$0** for each Flexible Sigmoidoscopy Limit to 1 every 4 years. (If a screening colonoscopy has been performed, Clover may cover a screening flexible sigmoid-oscopy only after 10 years.) **$0** for each Screening Colonoscopy Limit to 1 every 24 months at high risk. Limit to 1 every 10 years not at high risk. (For any risk, if a screening flexible sigmoidoscopy has been performed Clover may cover a screening colonoscopy only after 4 years.) **$0** for each Barium Enema Limit to 1 every 24 months at high risk. Limit to 1 every 4 years not at high risk. **$0** for each Colorectal Cancer Screening with Cologuard Limit to 1 per 3 years.

Medical Benefit Description	CarePoint Green Plan 001	Classic Aqua Plan 004	Premier Orange Plan 007	NJ Purple Plan 032
PREVENTIVE SERVICES *(continued)*				
Diabetes Screening Test	**$0** for each Diabetes screening test Limit to 2 per year for beneficiaries diagnosed with pre-diabetes. Limit to 1 screening per year if previously tested but not diagnosed with pre-diabetes, or if never tested.	**$0** for each Diabetes screening test Limit to 2 per year for beneficiaries diagnosed with pre-diabetes. Limit to 1 screening per year if previously tested but not diagnosed with pre-diabetes, or if never tested.	**$0** for each Diabetes screening test Limit to 2 per year for beneficiaries diagnosed with pre-diabetes. Limit to 1 screening per year if previously tested but not diagnosed with pre-diabetes, or if never tested.	**$0** for each Diabetes screening test Limit to 2 per year for beneficiaries diagnosed with pre-diabetes. Limit to 1 screening per year if previously tested but not diagnosed with pre-diabetes, or if never tested.
Glaucoma Screening	**$0** for each Medicare covered Glaucoma screening test Limit to 1 per year.	**$0** for each Medicare covered Glaucoma screening test Limit to 1 per year.	**$0** for each Medicare covered Glaucoma screening test Limit to 1 per year.	**$0** for each Medicare covered Glaucoma screening test Limit to 1 per year.
Health & Wellness Education Programs	**$0** for a SilverSneakers® membership To find a fitness center that participates in the SilverSneakers® network, please visit **https://www.silversneakers.com/locations**	**$0** for a SilverSneakers® membership To find a fitness center that participates in the SilverSneakers® network, please visit **https://www.silversneakers.com/locations**	**$0** for a SilverSneakers® membership To find a fitness center that participates in the SilverSneakers® network, please visit **https://www.silversneakers.com/locations**	**$0** for a SilverSneakers® membership To find a fitness center that participates in the SilverSneakers® network, please visit **https://www.silversneakers.com/locations**

Medical Benefit Description	CarePoint Green Plan 001	Classic Aqua Plan 004	Premier Orange Plan 007	NJ Purple Plan 032
PREVENTIVE SERVICES *(continued)*				
Smoking Cessation	**$0** for each Medicare covered smoking and tobacco use cessation Limit to 2 cessation attempts per year. Each attempt may include a maximum of 4 intermediate or intensive sessions, with the total annual benefit covering up to 8 sessions per year.	**$0** for each Medicare covered smoking and tobacco use cessation Limit to 2 cessation attempts per year. Each attempt may include a maximum of 4 intermediate or intensive sessions, with the total annual benefit covering up to 8 sessions per year.	**$0** for each Medicare covered smoking and tobacco use cessation Limit to 2 cessation attempts per year. Each attempt may include a maximum of 4 intermediate or intensive sessions, with the total annual benefit covering up to 8 sessions per year.	**$0** for each Medicare covered smoking and tobacco use cessation Limit to 2 cessation attempts per year. Each attempt may include a maximum of 4 intermediate or intensive sessions, with the total annual benefit covering up to 8 sessions per year.
HIV Screening	**$0** for each voluntary HIV screening Limit to 1 per year. Limit to 3 per year when pregnant: (1) when the diagnosis of pregnancy is known (2) during the third trimester, and/or (3) at labor if ordered by the physician	**$0** for each voluntary HIV screening Limit to 1 per year. Limit to 3 per year when pregnant: (1) when the diagnosis of pregnancy is known (2) during the third trimester, and/or (3) at labor if ordered by the physician	**$0** for each voluntary HIV screening Limit to 1 per year. Limit to 3 per year when pregnant: (1) when the diagnosis of pregnancy is known (2) during the third trimester, and/or (3) at labor if ordered by the physician	**$0** for each voluntary HIV screening Limit to 1 per year. Limit to 3 per year when pregnant: (1) when the diagnosis of pregnancy is known (2) during the third trimester, and/or (3) at labor if ordered by the physician

Coinsurance will always be taken on applicable services in addition to the copay.

Medical Benefit Description	CarePoint Green Plan 001	Classic Aqua Plan 004	Premier Orange Plan 007	NJ Purple Plan 032
PREVENTIVE SERVICES *(continued)*				
Immunizations Flu vaccine, Hepatitis B vaccine & Pneumonia vaccine	**$0** for the administration of each vaccine, for each Medicare covered Flu vaccine, Pneumonia vaccine, Hepatitis B vaccine, and other covered immunizations Limit to 2 Flu vaccines per year. Limit to 2 Pneumonia vaccines per lifetime.	**$0** for the administration of each vaccine, for each Medicare covered Flu vaccine, Pneumonia vaccine, Hepatitis B vaccine, and other covered immunizations Limit to 2 Flu vaccines per year. Limit to 2 Pneumonia vaccines per lifetime.	**$0** for the administration of each vaccine, for each Medicare covered Flu vaccine, Pneumonia vaccine, Hepatitis B vaccine, and other covered immunizations Limit to 2 Flu vaccines per year. Limit to 2 Pneumonia vaccines per lifetime.	**$0** for the administration of each vaccine, for each Medicare covered Flu vaccine, Pneumonia vaccine, Hepatitis B vaccine, and other covered immunizations Limit to 2 Flu vaccines per year. Limit to 2 Pneumonia vaccines per lifetime.
Initial Preventive Physical Exam Also known as the "Welcome to Medicare Preventive Visit"	**$0** for the physical exam Limit to 1 in a lifetime. Must be furnished no later than 12 months after the effective date of the first Medicare Part B Coverage.	**$0** for the physical exam Limit to 1 in a lifetime. Must be furnished no later than 12 months after the effective date of the first Medicare Part B Coverage.	**$0** for the physical exam Limit to 1 per lifetime. Must be furnished no later than 12 months after the effective date of the first Medicare Part B Coverage.	**$0** for the physical exam Limit to 1 per lifetime. Must be furnished no later than 12 months after the effective date of the first Medicare Part B Coverage.
Intensive Behavioral Therapy	**$0** for each IBT for cardiovascular disease Limit of 1 per year. **$0** for each IBT for obesity service Limit of 22 per year.	$0 for each IBT for cardiovascular disease Limit of 1 per year. **$0** for each IBT for obesity service Limit of 22 per year.	**$0** for each IBT for cardiovascular disease Limit of 1 per year. **$0** for each IBT for obesity service Limit of 22 per year.	**$0** for each IBT for cardiovascular disease Limit of 1 per year. **$0** for each IBT for obesity service Limit of 22 per year.

Medical Benefit Description	CarePoint Green Plan 001	Classic Aqua Plan 004	Premier Orange Plan 007	NJ Purple Plan 032
PREVENTIVE SERVICES *(continued)*				
Lung Cancer Screening Counseling and Annual Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)	**$0** for each Lung Cancer Screening Counseling **$0** for each Lung Cancer Screening w/LDCT Limit of 1 per 12 months.	**$0** for each Lung Cancer Screening Counseling **$0** for each Lung Cancer Screening w/LDCT Limit of 1 per 12 months.	**$0** for each Lung Cancer Screening Counseling **$0** for each Lung Cancer Screening w/LDCT Limit of 1 per 12 months.	**$0** for each Lung Cancer Screening Counseling **$0** for each Lung Cancer Screening w/LDCT Limit of 1 per 12 months.
Screening Mammograms	**$0** for each Medicare covered baseline mammogram Limit to 1 baseline mammogram for women between the ages of 35–39. **$0** for each Medicare covered screening mammogram Limit to 1 screening mammogram every 12 months for women over 40.	**$0** for each Medicare covered baseline mammogram Limit to 1 baseline mammogram for women between the ages of 35–39. **$0** for each Medicare covered screening mammogram Limit to 1 screening mammogram every 12 months for women over 40.	**$0** for each Medicare covered baseline mammogram Limit to 1 baseline mammogram for women between the ages of 35–39. **$0** for each Medicare covered screening mammogram Limit to 1 screening mammogram every 12 months for women over 40.	**$0** for each Medicare covered baseline mammogram Limit to 1 baseline mammogram for women between the ages of 35–39. **$0** for each Medicare covered screening mammogram Limit to 1 screening mammogram every 12 months for women over 40.

New Jersey—2018 Medical Benefits

Medical Benefit Description	CarePoint Green Plan 001	Classic Aqua Plan 004	Premier Orange Plan 007	NJ Purple Plan 032
PREVENTIVE SERVICES *(continued)*				
Medical Nutrition Therapy (MNT) For people with diabetes, renal (kidney) disease (but not on dialysis), and after a trans-plant when referred by a doctor	**$0** for each Medicare covered Medical Nutrition Therapy visit/service Limit to 3 hours of one-on-one counseling in the 1st year, and 2 hours for each subsequent year.	**$0** for each Medicare covered Medical Nutrition Therapy visit/service Limit to 3 hours of one-on-one counseling in the 1st year, and 2 hours for each subsequent year.	**$0** for each Medicare covered Medical Nutrition Therapy visit/service Limit to 3 hours of one-on-one counseling in the 1st year, and 2 hours for each subsequent year.	**$0** for each Medicare covered Medical Nutrition Therapy visit/service Limit to 3 hours of one-on-one counseling in the 1st year, and 2 hours for each subsequent year.
Pap Smears and Pelvic Exams	**$0** for each Medicare covered pap smear and for each Medicare covered pelvic & breast exam Limit to 1 screening pap and 1 pelvic exam every 12 months for women at high risk or at childbearing age w/ abnormal pap in the past 3 years. Limit to 1 screening pap and 1 pelvic exam every 24 months for all other women.	**$0** for each Medicare covered pap smear and for each Medicare covered pelvic & breast exam Limit to 1 screening pap and 1 pelvic exam every 12 months for women at high risk or at childbearing age w/ abnormal pap in the past 3 years. Limit to 1 screening pap and 1 pelvic exam every 24 months for all other women.	**$0** for each Medicare covered pap smear and for each Medicare covered pelvic & breast exam Limit to 1 screening pap and 1 pelvic exam every 12 months for women at high risk or at childbearing age w/ abnormal pap in the past 3 years. Limit to 1 screening pap and 1 pelvic exam every 24 months for all other women.	**$0** for each Medicare covered pap smear and for each Medicare covered pelvic & breast exam Limit to 1 screening pap and 1 pelvic exam every 12 months for women at high risk or at childbearing age w/ abnormal pap in the past 3 years. Limit to 1 screening pap and 1 pelvic exam every 24 months for all other women.

Coinsurance will always be taken on applicable services in addition to the copay.

New Jersey—2018 Medical Benefits

Medical Benefit Description	CarePoint Green Plan 001	Classic Aqua Plan 004	Premier Orange Plan 007	NJ Purple Plan 032
PREVENTIVE SERVICES *(continued)*				
Prostate Cancer Screening Exams For men with Medicare age 50 and older	**$0** for each Medicare covered digital rectal exam (DRE) and for each Medicare covered prostate specific antigen test (PSA) Limit to 1 DRE every 12 months. Limit to 1 PSA every 12 months.	**$0** for each Medicare covered digital rectal exam (DRE) and for each Medicare covered prostate specific antigen test (PSA) Limit to 1 DRE every 12 months. Limit to 1 PSA every 12 months.	**$0** for each Medicare covered digital rectal exam (DRE) and for each Medicare covered prostate specific antigen test (PSA) Limit to 1 DRE every 12 months. Limit to 1 PSA every 12 months.	**$0** for each Medicare covered digital rectal exam (DRE) and for each Medicare covered prostate specific antigen test (PSA) Limit to 1 DRE every 12 months. Limit to 1 PSA every 12 months.
Routine Physical Exams This is not the IPPE.	No coverage for routine physical exams.	No coverage for routine physical exams.	No coverage for routine physical exams.	No coverage for routine physical exams.
Screening for Cervical Cancer with Human Papillomavirus (HPV) Tests	**$0** for each cervical cancer screening with human papillomavirus (HPV) tests Limit to 1 every 5 years.	**$0** for each cervical cancer screening with human papillomavirus (HPV) tests Limit to 1 every 5 years.	**$0** for each cervical cancer screening with human papillomavirus (HPV) tests Limit to 1 every 5 years.	**$0** for each cervical cancer screening with human papillomavirus (HPV) tests Limit to 1 every 5 years.
Screening for Depression	**$0** for each depression screening service Limit to 1 per year, 15 min.	**$0** for each depression screening service Limit to 1 per year, 15 min.	**$0** for each depression screening service Limit to 1 per year, 15 min.	**$0** for each depression screening service Limit to 1 per year, 15 min.

Medical Benefit Description	CarePoint Green Plan 001	Classic Aqua Plan 004	Premier Orange Plan 007	NJ Purple Plan 032
PREVENTIVE SERVICES *(continued)*				
Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs	**$0** for each STI/HIBC service **Coverage for chlamydia, gonorrhea, syphilis, and Hepatitis B only:** Limit to 1 screening per year for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant. Limit to 1 screening per year for syphilis in men at increased risk. Limit up to 2 screenings per pregnancy for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening. Limit to 1 screening per preg-nancy for syphilis in pregnant women; up to 2 additional screenings in the third trimester and at delivery if at continued increased risk for STIs. Limit to 1 screening per pregnancy for hepatitis B in pregnant women; 1 additional screening at delivery if at continued increased risk for STIs. Limit up to 2 face-to-face, 20–30 minute, HIBC sessions per year.	**$0** for each STI/HIBC service **Coverage for chlamydia, gonorrhea, syphilis, and Hepatitis B only:** Limit to 1 screening per year for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant. Limit to 1 screening per year for syphilis in men at increased risk. Limit up to 2 screenings per pregnancy for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening. Limit to 1 screening per preg-nancy for syphilis in pregnant women; up to 2 additional screenings in the third trimester and at delivery if at continued increased risk for STIs. Limit to 1 screening per pregnancy for hepatitis B in pregnant women; 1 additional screening at delivery if at continued increased risk for STIs. Limit up to 2 face-to-face, 20–30 minute, HIBC sessions per year.	**$0** for each STI/HIBC service **Coverage for chlamydia, gonorrhea, syphilis, and Hepatitis B only:** Limit to 1 screening per year for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant. Limit to 1 screening per year for syphilis in men at increased risk. Limit up to 2 screenings per pregnancy for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening. Limit to 1 screening per preg-nancy for syphilis in pregnant women; up to 2 additional screenings in the third trimester and at delivery if at continued increased risk for STIs. Limit to 1 screening per pregnancy for hepatitis B in pregnant women; 1 additional screening at delivery if at continued increased risk for STIs. Limit up to 2 face-to-face, 20–30 minute, HIBC sessions per year.	**$0** for each STI/HIBC service **Coverage for chlamydia, gonorrhea, syphilis, and Hepatitis B only:** Limit to 1 screening per year for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant. Limit to 1 screening per year for syphilis in men at increased risk. Limit up to 2 screenings per pregnancy for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening. Limit to 1 screening per preg-nancy for syphilis in pregnant women; up to 2 additional screenings in the third trimester and at delivery if at continued increased risk for STIs. Limit to 1 screening per pregnancy for hepatitis B in pregnant women; 1 additional screening at delivery if at continued increased risk for STIs. Limit up to 2 face-to-face, 20–30 minute, HIBC sessions per year.

Medical Benefit Description	CarePoint Green Plan 001	Classic Aqua Plan 004	Premier Orange Plan 007	NJ Purple Plan 032
PREVENTIVE SERVICES *(continued)*				
Hepatitis C Virus Screening	**$0** for each Hepatitis C screening Limit to 1 per lifetime or 1 per year depending on diagnosis code.	**$0** for each Hepatitis C screening Limit to 1 per lifetime or 1 per year depending on diagnosis code.	**$0** for each Hepatitis C screening Limit to 1 per lifetime or 1 per year depending on diagnosis code.	**$0** for each Hepatitis C screening Limit to 1 per lifetime or 1 per year depending on diagnosis code.
Medicare Diabetes Prevention Program (MDPP) Effective 4/1/2018	**$0** for each MDPP session Limit to 1 year of core and core maintenance sessions followed by up to 1 year of ongoing maintenance sessions. Member must meet weight loss and attendance goals.	**$0** for each MDPP session Limit to 1 year of core and core maintenance sessions followed by up to 1 year of ongoing maintenance sessions. Member must meet weight loss and attendance goals.	**$0** for each MDPP session Limit to 1 year of core and core maintenance sessions followed by up to 1 year of ongoing maintenance sessions. Member must meet weight loss and attendance goals.	**$0** for each MDPP session Limit to 1 year of core and core maintenance sessions followed by up to 1 year of ongoing maintenance sessions. Member must meet weight loss and attendance goals.

Medical Benefit Description	CarePoint Green Plan 001	Classic Aqua Plan 004	Premier Orange Plan 007	NJ Purple Plan 032
ADDITIONAL SERVICES				
Dental Services	**$0** for each Medicare covered Dental service **$0** for each Non-Medicare covered Preventive Dental service when received from a DentaQuest provider. Limit 2 preventive exams per year. Limit 2 preventive clearnings per year. Limit 1 preventive x-ray per year. Contracted rates apply for services from non-participating DentaQuest providers. For more information, call Clover Provider Services at **1-877-853-8019** or DentaQuest Provider Services at **855-398-8409**. To find a provider visit **www.dentaquest.com/find-a-provider/cloverdental** No coverage for Comprehensive Dental services.	**$0** for each Medicare covered Dental service **$0** for each Non-Medicare covered Preventive Dental service when received from a DentaQuest provider. Limit 2 preventive exams per year. Limit 2 preventive clearnings per year. Limit 1 preventive x-ray per year. Contracted rates apply for services from non-participating DentaQuest providers. For more information, call Clover Provider Services at **1-877-853-8019** or DentaQuest Provider Services at **855-398-8409**. To find a provider visit **www.dentaquest.com/find-a-provider/cloverdental** No coverage for Comprehensive Dental services.	**$0** for each Medicare covered Dental service **$0** for each Non-Medicare covered Preventive Dental service when received from a DentaQuest provider. Limit 2 preventive exams per year. Limit 2 preventive clearnings per year. Limit 1 preventive x-ray per year. Contracted rates apply for services from non-participating DentaQuest providers. For more information, call Clover Provider Services at **1-877-853-8019** or DentaQuest Provider Services at **855-398-8409**. To find a provider visit **www.dentaquest.com/find-a-provider/cloverdental** No coverage for Comprehensive Dental services.	**$0** for each Medicare covered Dental service **$0** for each Non-Medicare covered Preventive Dental service when received from a DentaQuest provider. Limit 2 preventive exams per year. Limit 2 preventive clearnings per year. Limit 1 preventive x-ray per year. Contracted rates apply for services from non-participating DentaQuest providers. For more information, call Clover Provider Services at **1-877-853-8019** or DentaQuest Provider Services at **855-398-8409**. To find a provider visit **www.dentaquest.com/find-a-provider/cloverdental** No coverage for Comprehensive Dental services.

Coinsurance will always be taken on applicable services in addition to the copay.

Medical Benefit Description	CarePoint Green Plan 001	Classic Aqua Plan 004	Premier Orange Plan 007	NJ Purple Plan 032
ADDITIONAL SERVICES *(continued)*				
Hearing Services	**$25** of the cost for each Medicare covered diagnostic hearing exam and each Medicare covered audiology service **$0** for a Non-Medicare covered routine hearing exam from a TruHearing provider Limit to 1 routine hearing exam per year. **$699** for each Flyte Advanced hearing aid from a TruHearing provider **$999** for each Flyte Premium hearing aid from a TruHearing provider Limit to 2 hearing aids per year; 1 per ear per year. 3 hearing aid fittings/evaluation visits are included as part of hearing aid purchase.	**$25** of the cost for each Medicare covered diagnostic hearing exam and each Medicare covered audiology service **$0** for a Non-Medicare covered routine hearing exam from a TruHearing provider Limit to 1 routine hearing exam per year. **$699** for each Flyte Advanced hearing aid from a TruHearing provider **$999** for each Flyte Premium hearing aid from a TruHearing provider Limit to 2 hearing aids per year; 1 per ear per year. 3 hearing aid fittings/evaluation visits are included as part of hearing aid purchase.	**$25** of the cost for each Medicare covered diagnostic hearing exam and each Medicare covered audiology service **$0** for a Non-Medicare covered routine hearing exam from a TruHearing provider Limit to 1 routine hearing exam per year. **$699** for each Flyte Advanced hearing aid from a TruHearing provider **$999** for each Flyte Premium hearing aid from a TruHearing provider Limit to 2 hearing aids per year; 1 per ear per year. 3 hearing aid fittings/evaluation visits are included as part of hearing aid purchase.	**$25** of the cost for each Medicare covered diagnostic hearing exam and each Medicare covered audiology service **$0** for a Non-Medicare covered routine hearing exam from a TruHearing provider Limit to 1 routine hearing exam per year. **$699** for each Flyte Advanced hearing aid from a TruHearing provider **$999** for each Flyte Premium hearing aid from a TruHearing provider Limit to 2 hearing aids per year; 1 per ear per year. 3 hearing aid fittings/evaluation visits are included as part of hearing aid purchase.

Medical Benefit Description	CarePoint Green Plan 001	Classic Aqua Plan 004	Premier Orange Plan 007	NJ Purple Plan 032
ADDITIONAL SERVICES *(continued)*				
Vision Services	**$25** for Medicare covered diagnostic exams to diagnose and treat diseases and conditions of the eye. Refraction is covered and will take applicable copay if performed as a stand-alone service. **$0** for Medicare covered post-cataract surgery eyewear. Limit to 1 pair of glasses or contacts after each cataract surgery. **$0** for a Non-Medicare covered routine eye exam (includes refraction) when seen by an EyeQuest provider. Limit to 1 routine eye exam/year. **$150 allowance** for supplemental eyewear (frames, lenses and/or contact lenses) per year.	**$25** for Medicare covered diagnostic exams to diagnose and treat diseases and conditions of the eye. Refraction is covered and will take applicable copay if performed as a stand-alone service. **$0** for Medicare covered post-cataract surgery eyewear. Limit to 1 pair of glasses or contacts after each cataract surgery. **$0** for a Non-Medicare covered routine eye exam (includes refraction) when seen by an EyeQuest provider. Limit to 1 routine eye exam/year. **$150 allowance** for supplemental eyewear (frames, lenses and/or contact lenses) per year.	**$5** for Medicare covered diagnostic exams to diagnose and treat diseases and conditions of the eye. Refraction is covered and will take applicable copay if performed as a stand-alone service. **$0** for Medicare covered post-cataract surgery eyewear. Limit to 1 pair of glasses or contacts after each cataract surgery. **$0** for a Non-Medicare covered routine eye exam (includes refraction) when seen by an EyeQuest provider. Limit to 1 routine eye exam/year. **$100 allowance** for supplemental eyewear (frames, lenses and/or contact lenses) per year after a $20 copay.	**$25** for Medicare covered diagnostic exams to diagnose and treat diseases and conditions of the eye. Refraction is covered and will take applicable copay if performed as a stand-alone service. **$0** for Medicare covered post-cataract surgery eyewear. Limit to 1 pair of glasses or contacts after each cataract surgery. **$25** for a Non-Medicare covered routine eye exam (includes refraction) when seen by an EyeQuest provider. Limit to 1 routine eye exam/year. **$100 allowance** for supplemental eyewear (frames, lenses and/or contact lenses) per year after a $20 copay.

New Jersey—2018 Medical Benefits

Effective Date: 1/1/2018 | Version 1.0

Medical Benefit Description	CarePoint Green Plan 001	Classic Aqua Plan 004	Premier Orange Plan 007	NJ Purple Plan 032
NON-COVERED BENEFITS				
Miscellaneous Non Plan Covered Services	• Acupuncture • Athletic Training • Cosmetic Dermatology • Routine Transportation without preauthorization • Self Administered Drugs (SADS) • Miscellaneous non-covered Items • Bundled Services • Demonstration Projects • Billing Errors • Non Medically Necessary Services • Report Only Codes	• Acupuncture • Athletic Training • Cosmetic Dermatology • Routine Transportation without preauthorization • Self Administered Drugs (SADS) • Miscellaneous non-covered Items • Bundled Services • Demonstration Projects • Billing Errors • Non Medically Necessary Services • Report Only Codes	• Acupuncture • Athletic Training • Cosmetic Dermatology • Routine Transportation without preauthorization • Self Administered Drugs (SADS) • Miscellaneous non-covered Items • Bundled Services • Demonstration Projects • Billing Errors • Non Medically Necessary Services • Report Only Codes	• Acupuncture • Athletic Training • Cosmetic Dermatology • Routine Transportation without preauthorization • Self Administered Drugs (SADS) • Miscellaneous non-covered Items • Bundled Services • Demonstration Projects • Billing Errors • Non Medically Necessary Services • Report Only Codes

Coinsurance will always be taken on applicable services in addition to the copay.

New Jersey—Part D Copays

CarePoint—Plan 001

	30 Day Supply		60 Day Supply		100 Day Supply		CVS Mail
Tiers	Preferred Pharmacy Network	Non-Preferred Pharmacy Network	Preferred Pharmacy Network	Non-Preferred Pharmacy Network	Preferred Pharmacy Network	Non-Preferred Pharmacy Network	CVS Mail Order (100 Day Supply)
Tier 1	$0	$5	$0	$10	$0	$15	$0
Tier 2	$10	$15	$20	$30	$30	$45	$20
Tier 3	$35	$45	$70	$90	$105	$135	$70
Tier 4	$85	$95	$170	$190	$255	$285	$170
Tier 5	25%	25%	25%	25%	25%	25%	25%

Rx deductible $150. Deductible appplies to tiers 3, 4, & 5. Tiers 1 & 2 are exempt from deductible. **Service Area:** Hudson.

Classic—Plan 004

	30 Day Supply		60 Day Supply		100 Day Supply		CVS Mail
Tiers	Preferred Pharmacy Network	Non-Preferred Pharmacy Network	Preferred Pharmacy Network	Non-Preferred Pharmacy Network	Preferred Pharmacy Network	Non-Preferred Pharmacy Network	CVS Mail Order (100 Day Supply)
Tier 1	$0	$5	$0	$10	$0	$15	$0
Tier 2	$10	$15	$20	$30	$30	$45	$20
Tier 3	$35	$45	$70	$90	$105	$135	$70
Tier 4	$85	$95	$170	$190	$255	$285	$170
Tier 5	25%	25%	25%	25%	25%	25%	25%

Rx deductible $150. Deductible applies to tiers 3, 4, & 5. Tiers 1 & 2 are exempt from deductible. **Service Area:** Atlantic, Bergen, Essex, Mercer, Monmouth, Passaic, Somerset, Union

Premier—Plan 007

	30 Day Supply		60 Day Supply		100 Day Supply		CVS Mail
Tiers	Preferred Pharmacy Network	Non-Preferred Pharmacy Network	Preferred Pharmacy Network	Non-Preferred Pharmacy Network	Preferred Pharmacy Network	Non-Preferred Pharmacy Network	CVS Mail Order (100 Day Supply)
Tier 1	$0	$10	$0	$20	$0	$30	$0
Tier 2	22%	25%	22%	25%	22%	25%	25%
Tier 3	22%	25%	22%	25%	22%	25%	25%
Tier 4	25%	25%	25%	25%	25%	25%	25%
Tier 5	25%	25%	25%	25%	25%	25%	25%

Rx deductible $405. Deductible applies to tiers 2, 3, 4, & 5. Tier 1 is exempt from deductible. **Service Area:** Atlantic, Bergen, Essex, Hudson, Mercer, Monmouth, Passaic, Somerset, Union

New Jersey—Part D Copays

Effective Date: 1/1/2018 | Version 1.0

NJ Purple—Plan 032

	30 Day Supply		60 Day Supply		100 Day Supply		CVS Mail
Tiers	Preferred Pharmacy Network	Non-Preferred Pharmacy Network	Preferred Pharmacy Network	Non-Preferred Pharmacy Network	Preferred Pharmacy Network	Non-Preferred Pharmacy Network	CVS Mail Order (100 Day Supply)
Tier 1	$0	$5	$0	$10	$0	$15	$0
Tier 2	$10	$15	$20	$30	$30	$45	$20
Tier 3	$35	$45	$70	$90	$105	$135	$70
Tier 4	$85	$95	$170	$190	$255	$285	$170
Tier 5	30%	30%	30%	30%	30%	30%	30%

Rx deductible $150. Deductible appplies to tiers 3, 4, & 5. Tiers 1 & 2 are exempt from deductible. **Service Area:** Burlington, Cumberland, Gloucester, Middlesex, Morris, Ocean

Stage 1 Annual Deductible	Stage 2 Initial Coverage	Stage 3 Coverage Gap	Stage 4 Catastropic
Member pays the full cost of drugs on until the deductible is met. Once met, the member moves to Stage 2.	Member pays a copayment or coinsurance and Clover pays our share of the cost for each prescription filled. Once the combined total cost paid by the member and Clover reaches the $3,750, the member enters Stage 3.	Member pays 44% of the plan's contracted cost for generic drugs and 35% for brand name drugs. Once the Members True Out-Of-Pocket (TrOOP) cost reaches $5,000, the member moves to Stage 4.	Member pays a reduced copayment of $3.35 for generic or $8.35 for brand name drugs (or 5% of the drug cost—whichever is greater). Member stays in this stage for the remainder of the plan year.