CLOVER HEALTH

2024 Formulary

(List of Covered Drugs)

Important Message About What You Pay for Vaccines:

Our plan covers most adult Part D vaccines at no cost to you, even if you haven't paid your deductible (if applicable). Call Member Services for more information.

Important Message About What You Pay for Insulin:

You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible (if applicable).

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN

For more recent information or other questions, please contact Clover Health Member Service at 1-888-778-1478 (TTY users should call 711), 8 am-8 pm local time, 7 days a week, or visit cloverhealth.com/formulary. Between April 1st and September 30th, alternate technologies (for example, voicemail) will be used on the weekends and holidays

Note to existing members: This formulary has changed since last year. Please use this formulary search tool to make sure that it still contains the drugs you take.

When this drug list (formulary) refers to "we," "us", or "our," it means Clover Health. When it refers to "plan" or "our plan," it means Clover Health.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2024, and from time to time during the year.

What is the Clover Health Formulary?

A formulary is a list of covered drugs selected by Clover Health in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Clover Health network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes.

Changes that can affect you this year: In the below cases, you will be affected by coverage changes during the year:

- **New generic drugs.** We may immediately remove a brand-name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
    - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can find information in the section below titled "How do I request an exception to the plan's Formulary?"

  Drugs removed from the market. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to the market to replace a brand-name drug currently on the formulary, or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, [or] add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.
    - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the plan's Formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2024 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2024 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new

restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

In the event of any mid-year non-maintenance formulary changes, the formulary search tool posted on our website cloverhealth.com/formulary will be updated monthly and the printed formularies will be updated quarterly.

How do I use the Formulary Search Tool?

Enter the first few letters of the drug you wish to add and then select the drug from the drop-down menu.
There is a 2 (two) character minimum.

What are generic drugs?

Clover Health covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Clover Health requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from us before you fill your prescriptions. If you don't get approval, we may not cover the drug.

- **Quantity Limits:** For certain drugs, Clover Health limits the amount of the drug that we will cover. For example, Clover Health provides one tablet per day per prescription for *rosuvastatin*. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy:** In some cases, Clover Health requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking on this formulary search tool. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information appears on the first page of this document. The date we last updated the formulary appears below the search bar on the search tool.

You can ask us to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the plan's formulary?" on page 4 for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Member Services and ask if your drug is covered.

If you learn that Clover Health does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by Clover Health. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by our plan.

- You can ask us to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Clover Health's Formulary?

You can ask us to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.

- You can ask us to cover a formulary drug at lower cost-sharing level unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, the plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, Clover Health will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tier, or utilization restriction exception. **When you request a formulary, tier, or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a

decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

You can call Clover Health Member Services to request an exception. Our contact information appears on the first page of this document.

You can also submit an exception electronically on our website at cloverhealth.com/part-d. Scroll down to the "How do I request an exception?" section and you will find a link called "Online: Coverage Determination Form." To assist us in processing your request, please be sure to include your name, contact information and information identifying which drug is being requested.

Or download, fill out and fax a Prescription Drug Coverage Determination form also available on our website at cloverhealth.com/part-d.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30 day supply of medication. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

If you experience a treatment setting change, such as being admitted to or discharged from a Long-Term Care (LTC) facility, you will be provided access to a refill upon admission or discharge. Clover Health will not use early refill edits to limit appropriate and necessary access to your Part D benefit. A temporary supply may be provided at your network pharmacy if the prescription claim submitted shows your treatment setting, or Level of Care, has changed. Otherwise, the pharmacy will call our Pharmacy Help Desk in order to obtain an override to submit a Level of Care temporary supply request.

Our Transition Fill Policy is available on Clover Health's website, https://www.cloverhealth.com/en/members/prescription-drug-transition-policy

For more information

For more detailed information about your Clover Health prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Clover Health, please contact us. Our contact information, appears on the first page of this document. The date we last updated the formulary appears below the search bar on the search tool.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048. Or, visit http://www.medicare.gov.

Clover Health's Formulary

The formulary provides coverage information about the drugs covered by the plan.

The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., SYNTHROID>) and generic drugs are listed in lower-case (e.g., levothyroxine).

The information in the Notes column tells you if our plan covers the drug you have searched. If it is covered, it will indicate what tier it is on and if there any special requirements for coverage of your drug.

Below are examples of special requirements listed in the Notes column:

Part B versus Part D PA only: This drug may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Limited access drugs: Specialty drugs not generally available at retail pharmacies

Not available at mail service: Drugs not available through our mail-order pharmacy

Prior Authorization Required: If drug has a prior authorization requirement, the Forms and Criteria column will link a "Criteria" document for more information

Quantity Limit: This will specify the quantity limit on the drug

Step Therapy Required: If drug has a step therapy requirement, the Forms and Criteria column will link a "Criteria" document for more information

Not covered. You will pay 100% of the drug cost: If drug is not covered you may find a link below for "Alternatives Available." This will open a pop-up window with alternatives. This is not a complete list of all formulary alternatives covered by the plan for the drug you have selected. The medications presented are for comparison purposes and may differ in effectiveness, dosing, side effects and/or drug interactions profiles. **Always seek the advice of your doctor**.

Drug Tier Copay Levels

Clover Health's 2024 formulary covers most drugs identified by Medicare as Part D drugs, and your copay may differ depending upon the tier the drug is on. Copay amounts and coinsurance percentages for each tier vary by plan. Consult your plan's Summary of Benefits or Evidence of Coverage for your applicable copays and/or coinsurance amounts.

You may use the plan's "Real-Time Benefit Tool" to look up drug coverage by registering an account through our pharmacy benefits manager, CVS Caremark, on the caremark.com portal. With this tool you can search for drugs on the "Drug List" to see an estimate of what you will pay and if there are alternative drugs on the "Drug List" that could treat the same condition. The cost shown is provided in "real time" meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay.

Copay tier	Type of drug
Tier 1	Preferred Generic: Drugs that are available at the lowest cost sharing tier
Tier 2	Generic drugs
Tier 3 drugs	Preferred Brand: includes preferred brand drugs and non-preferred generic
Tier 4	Non-Preferred drug: includes non-preferred brand drugs and non-preferred generic drugs
Tier 5	Specialty drug: includes specialty drugs and very high cost brand and generic drugs, which may require special handling and/or close monitoring

Clover Health, in some instances, combines higher cost generic drugs on brand tiers. Refer to the drug list to determine the tier of coverage for each drug you take.

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You won’t pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it’s on, even if you haven’t paid your deductible (if applicable).

For more recent information or other questions, please contact us, Clover Health Member Service at 1-888-
778-1478 (TTY 711), 8am-8pm local time, 7 days a week, or visit cloverhealth.com/medicines. Between
April 1st and September 30th, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

Clover Health is a Preferred Provider Organization (PPO) and a Health Maintenance Organization (HMO) with a Medicare contract. Enrollment in Clover Health depends on contract renewal.