

BENEFITS	BASIC Rx (HMO) PLAN YOU PAY	VALUE Rx (HMO) PLAN YOU PAY	CHOICE Rx (HMO-POS) PLAN YOU PAY	VALUE Rx PLUS (HMO) PLAN YOU PAY
Resident County and Premium	\$0 Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham and Sullivan	\$44 Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham and Sullivan	\$54 Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham and Sullivan	\$123 Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham and Sullivan \$128 Strafford
Annual Medical Deductible	\$0	\$0	\$0	\$0
Primary Care Provider (PCP) Office Visit	\$10 copayment per visit	\$0 copayment per visit	\$0 copayment per visit†	\$0 copayment per visit
Annual Physical Exam	\$0 copayment, 1 visit per year	\$0 copayment, 1 visit per year	\$0 copayment, 1 visit per year*	\$0 copayment, 1 visit per year
Specialist Office Visit	\$40 copayment per visit	\$35 copayment per visit	\$30 copayment per visit	\$30 copayment per visit
Diagnostic Tests, X-ray, Lab Services	\$20 copayment for X-ray & labs \$300 copayment for MRI/CT scans	\$10 copayment for X-ray & labs \$250 copayment for MRI/CT scans	\$15 copayment for X-ray & labs \$250 copayment for MRI/CT scans	\$15 copayment for X-ray & labs \$250 copayment for MRI/CT scans
Chemotherapy Drugs & Part B Prescription Drugs	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Outpatient Surgery	\$300 copayment for each surgery	\$250 copayment for each surgery	\$250 copayment for each surgery	\$250 copayment for each surgery
Inpatient Hospital Care (Acute Care)	Days 1-5, \$370 copayment each day	Days 1-6, \$300 copayment each day	Days 1-6, \$275 copayment each day*	Days 1-6, \$275 copayment each day
Inpatient Mental Health (includes Substance Abuse and Rehabilitation Services)	Days 1-5, \$370 copayment each day	Days 1-6, \$300 copayment each day	Days 1-6, \$275 copayment each day*	Days 1-6, \$275 copayment each day
Skilled Nursing Facility (in a Medicare Certified Skilled Nursing Facility)	Days 1-20, \$0 copayment per day Days 21-100, \$184 copayment per day	Days 1-20, \$0 copayment per day Days 21-100, \$184 copayment per day	Days 1-20, \$0 copayment per day Days 21-100, \$184 copayment per day*	Days 1-20, \$0 copayment per day Days 21-100, \$184 copayment per day
Durable Medical Equipment	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Diabetic Monitoring Supplies	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment
Home Health Care	\$0 copayment per Medicare-covered visit	\$0 copayment per Medicare-covered visit	\$0 copayment per Medicare-covered visit*	\$0 copayment per Medicare-covered visit
Worldwide Emergency Coverage	\$90 copayment per visit waived if admitted for inpatient care or outpatient observation within 24 hours	\$90 copayment per visit waived if admitted for inpatient care or outpatient observation within 24 hours	\$90 copayment per visit waived if admitted for inpatient care or outpatient observation within 24 hours	\$90 copayment per visit waived if admitted for inpatient care or outpatient observation within 24 hours
Telehealth	\$0 copayment for e-Visits & Virtual Check-Ins; \$10-\$50 copayment for Telehealth Services	\$0 copayment for e-Visits & Virtual Check-Ins; \$0-\$50 copayment for Telehealth Services	\$0 copayment for e-Visits & Virtual Check-Ins; \$0-\$50 copayment for Telehealth Services	\$0 copayment for e-Visits & Virtual Check-Ins; \$0-\$50 copayment for Telehealth Services
Urgent Care	\$50 copayment per visit	\$50 copayment per visit	\$50 copayment per visit	\$50 copayment per visit
Ambulance	\$250 copayment per one-way trip	\$250 copayment per one-way trip	\$200 copayment per one-way trip	\$200 copayment per one-way trip
Routine Eye Exam	\$0 copayment, 1 visit per year	\$0 copayment, 1 visit per year	\$0 copayment, 1 visit per year††	\$0 copayment, 1 visit per year
Routine Hearing Exam	\$40 copayment, 1 visit per year	\$35 copayment, 1 visit per year	\$30 copayment, 1 visit per year not covered out-of-network††	\$30 copayment, 1 visit per year
Hearing Aid Benefit	\$699 copayment per hearing aid for Advanced \$999 copayment per hearing aid for Premium	\$699 copayment per hearing aid for Advanced \$999 copayment per hearing aid for Premium	\$699 copayment per hearing aid for Advanced❖ \$999 copayment per hearing aid for Premium❖	\$699 copayment per hearing aid for Advanced \$999 copayment per hearing aid for Premium
Dental Benefit	\$500 annual limit Periodontal exams & cleanings \$0 copayment in network or out-of-network—and no deductible	\$500 annual limit Periodontal exams & cleanings \$0 copayment in network or out-of-network—and no deductible	\$500 annual limit Periodontal exams & cleanings \$0 copayment in network or out-of-network—and no deductible	\$500 annual limit Periodontal exams & cleanings \$0 copayment in network or out-of-network—and no deductible
Over-the-Counter Allowance	\$150 annual allowance towards over-the-counter health care related drugs and supplies	\$200 annual allowance towards over-the-counter health care related drugs and supplies	\$250 annual allowance towards over-the-counter health care related drugs and supplies	\$250 annual allowance towards over-the-counter health care related drugs and supplies
Out-of-Pocket Limit	\$6,700 yearly out-of-pocket limit	\$5,600 yearly out-of-pocket limit	\$5,600 in and out-of-network yearly out-of-pocket limit	\$5,000 yearly out-of-pocket limit
Wallet Benefit	Up to \$250 reimbursement annually for qualified health and wellness expenses including a fitness tracker, fitness membership, eyewear, chiropractic, brain fitness subscription and more	Up to \$325 reimbursement annually for qualified health and wellness expenses including a fitness tracker, fitness membership, eyewear, chiropractic, brain fitness subscription and more	Up to \$400 reimbursement annually for qualified health and wellness expenses including a fitness tracker, fitness membership, eyewear, chiropractic, brain fitness subscription and more	Up to \$400 reimbursement annually for qualified health and wellness expenses including a fitness tracker, fitness membership, eyewear, chiropractic, brain fitness subscription and mor

* Not covered out-of-network

† Not covered out-of-network except preventive services from an out-of-network provider

†† Not covered out-of-network except for previously-diagnosed medical condition ❖ Not covered out-of-network unless using a TruHearing® provider

For more information you can contact StrideSM (HMO) at **(866) 256-5365, TTY: 711**

StrideSM (HMO) Medicare Advantage Plan Prescription Drug Benefits

COVERAGE LIMIT	BASIC Rx (HMO) PLAN YOU PAY	VALUE Rx (HMO) PLAN YOU PAY	CHOICE Rx (HMO-POS) PLAN YOU PAY	VALUE Rx PLUS (HMO) PLAN YOU PAY
Annual Prescription Drug Deductible	\$445 annual deductible for Tier 3, Tier 4 and Tier 5 Part D prescription drugs	\$270 annual deductible for Tier 3, Tier 4 and Tier 5 Part D prescription drugs	\$270 annual deductible for Tier 3, Tier 4 and Tier 5 Part D prescription drugs	\$270 annual deductible for Tier 3, Tier 4 and Tier 5 Part D prescription drugs
Initial Coverage: After your yearly deductible, you pay the following until your total yearly drug costs reach \$4,130. Total yearly drug costs are the total drug costs paid by both you and Harvard Pilgrim.				
Tier 1 Preferred Generic				
30-Day Supply-Retail Pharmacy	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment
90-Day Supply-Mail Order Pharmacy	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment
Tier 2 Generic				
30-Day Supply-Retail Pharmacy	\$15 copayment	\$10 copayment	\$10 copayment	\$10 copayment
90-Day Supply-Mail Order Pharmacy	\$30 copayment	\$20 copayment	\$20 copayment	\$20 copayment
Tier 3 Preferred Brand-Name				
30-Day Supply-Retail Pharmacy	\$47 copayment	\$47 copayment	\$47 copayment	\$47 copayment
90-Day Supply-Mail Order Pharmacy	\$94 copayment	\$94 copayment	\$94 copayment	\$94 copayment
Tier 4 Non-Preferred Brand-Name				
30-Day Supply-Retail Pharmacy	\$100 copayment	\$100 copayment	\$100 copayment	\$100 copayment
90-Day Supply-Mail Order Pharmacy	\$250 copayment	\$250 copayment	\$250 copayment	\$250 copayment
Tier 5 Specialty				
	25% coinsurance	28% coinsurance	28% coinsurance	28% coinsurance
Coverage Gap: You pay the following until you and others on your behalf have paid a total of \$6,550* for covered Part D drugs.				
Tier 1 Preferred Generic				
30-Day Supply-Retail Pharmacy	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment
90-Day Supply-Mail Order Pharmacy	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment
Tier 2 Generic				
Tier 3 Preferred Brand-Name				
Tier 4 Non-Preferred Brand-Name				
Tier 5 Specialty				
While you are in the Coverage Gap, you pay 25% of the cost for generic drugs and 25% of the negotiated price (plus a portion of the dispensing fee) for brand name drugs. In this stage, the Medicare Coverage Gap Discount Program provides a 70% manufacturer discount on brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them.				
Catastrophic Coverage: You pay the following for the remainder of the calendar year.				
Generic Drugs (including Brand Drugs treated as Generic)				
Greater of 5% coinsurance or \$3.70 copayment				
All other Drugs				
Greater of 5% coinsurance or \$9.20 copayment				

*Please note: Drugs covered by StrideSM (HMO) that are not covered by Medicare Part D do not count toward this amount. Different out-of-pocket costs may apply for people who have limited incomes, live in long-term care facilities or have access to Indian/Tribal/Urban (Indian Health Service) providers.

Harvard Pilgrim is an HMO/HMO-POS plan with a Medicare contract. Enrollment in StrideSM (HMO) depends on contract renewal. Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care and Harvard Pilgrim Health Care of New England.