Harvard Pilgrim Health Care

Stride[SM] (HMO) Medicare Advantage Plan Comparison

BENEFITS	BASIC Rx PLAN YOU PAY	VALUE Rx PLAN YOU PAY	VALUE Rx PLUS PLAN YOU PAY
Resident County and Premium	**$0** Barnstable, Bristol, Plymouth, Suffolk, & Worcester	**$67** Barnstable, Bristol, Essex, Middlesex[ψ], Norfolk, Plymouth & Suffolk **$79** Worcester	**$163** Barnstable, Bristol, Essex, Middlesex[ψ], Norfolk, Plymouth & Suffolk **$190** Worcester
Annual Medical Deductible	$0	$0	$0
Primary Care Provider (PCP) Office Visit	$20 copayment per visit	$20 copayment per visit	$10 copayment per visit
Annual Physical Exam	$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	$40 copayment per visit	$25 copayment per visit
Diagnostic Tests, X-ray, Lab Services	$20 copayment for X-ray $20 copayment for lab services $60 copayment for MRI/CT scans	$20 copayment for X-ray $20 copayment for lab services $60 copayment for MRI/CT scans	$0 copayment for X-ray $0 copayment for lab services $60 copayment for MRI/CT scans
Medicare Covered Chemotherapy Drugs & Other Part B Prescription Drugs	20% coinsurance	20% coinsurance	15% coinsurance
Outpatient Surgery	$275 copayment for each Medicare-covered visit	$250 copayment for each Medicare-covered visit	$150 copayment for each Medicare-covered visit
Inpatient Hospital Care (Acute Care)	Days 1-5, $355 copayment each day	Days 1-6, $275 copayment each day	Days 1-5, $150 copayment each day ($750 out-of-pocket limit annually)
Inpatient Mental Health (includes Substance Abuse and Rehabilitation Services)	Days 1-4, $355 copayment each day	Days 1-6, $275 copayment each day	Days 1-5, $150 copayment each day
Skilled Nursing Facility (in a Medicare Certified Skilled Nursing Facility)	Days 1-20, $0 copayment per day Days 21-100, $172 copayment per day	Days 1-20, $20 copayment per day Days 21-100, $165 copayment per day	Days 1-20, $20 copayment per day Days 21-100, $155 copayment per day
Durable Medical Equipment	20% coinsurance	20% coinsurance	20% coinsurance
Home Health Care	$0 copayment per visit	$0 copayment per visit	$0 copayment per visit
Worldwide Emergency Coverage	$90 copayment per visit (waived if admitted within 24 hours for same condition)	$120 copayment per visit (waived if admitted within 24 hours for same condition)	$120 copayment per visit (waived if admitted within 24 hours for same condition)
Urgent Care	$65 copayment per visit	$65 copayment per visit	$65 copayment per visit
Ambulance	$250 copayment per one-way trip	$150 copayment per one-way trip	$150 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
Routine Hearing Exam	$40 copayment, 1 visit per year	$40 copayment, 1 visit per year	$25 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
Dental Benefit	No coverage	- $35 annual deductible - 2 periodic oral exams & 2 cleanings per year - 1 set of bitewing X-rays per year - 1 full set of X-rays every 36 months	- $35 annual deductible - 2 periodic oral exams & 2 cleanings per year - 1 set of bitewing X-rays per year - 1 full set of X-rays every 36 months
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
Out-of-Pocket Limit	$6,700 yearly out-of-pocket limit	$3,400 yearly out-of-pocket limit	$3,400 yearly out-of-pocket limit
New - Wallet Benefit	Up to $250 reimbursement annually for qualified healthcare expenses (Fitness membership, eyewear and more)	Up to $325 reimbursement annually for qualified healthcare expenses (Fitness membership, eyewear and more)	Up to $400 reimbursement annually for qualified healthcare expenses (Fitness membership, eyewear and more)

[ψ] Excludes zip codes 01824, 01826 and 01863 in Middlesex county

For more information you can contact **Stride[SM] (HMO)** at **1-866-256-5350**, **TTY: 711**
October 1 - March 31, 8 a.m. - 8 p.m. 7 days a week,
April 1 - September 30, 8 a.m. - 8 p.m. Monday - Friday
hpforlife.org

Harvard Pilgrim is an HMO plan with a Medicare contract. Enrollment in Stride[SM] (HMO) depends on contract renewal. This information is not a complete description of benefits. Call **1-866-256-5350 TTY: 711** for more information.

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Stride[SM] (HMO) Medicare Advantage Plan Prescription Drug Benefits

COVERAGE LIMIT	BASIC Rx PLAN YOU PAY	VALUE Rx PLAN YOU PAY	VALUE Rx PLUS PLAN YOU PAY
Annual Prescription Drug Deductible	$415 annual deductible for Tier 3, Tier 4 and Tier 5 Part D prescription drugs	$350 annual deductible for Tier 3, Tier 4 and Tier 5 Part D prescription drugs	$0
Initial Coverage: After your yearly deductible, you pay the following until your total yearly drug costs reach $3,820. 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
90-Day Supply-Mail Order Pharmacy	$0 copayment	$0 copayment	$0 copayment
Tier 2 Generic			
30-Day Supply-Retail Pharmacy	$15 copayment	$10 copayment	$10 copayment
90-Day Supply-Mail Order Pharmacy	$30 copayment	$20 copayment	$20 copayment
Tier 3 Preferred Brand-Name			
30-Day Supply-Retail Pharmacy	$47 copayment	$47 copayment	$47 copayment
90-Day Supply-Mail Order Pharmacy	$94 copayment	$94 copayment	$94 copayment
Tier 4 Non-Preferred Brand-Name			
30-Day Supply-Retail Pharmacy	$100 copayment	$100 copayment	$100 copayment
90-Day Supply-Mail Order Pharmacy	$250 copayment	$250 copayment	$250 copayment
Tier 5 Specialty	25% coinsurance	26% coinsurance	33% coinsurance
Coverage Gap You pay the following until you have paid a total of $5,100* for covered Part D drugs.			
Tier 1 Preferred Generic 30-Day Supply-Retail Pharmacy 90-Day Supply-Mail Order Pharmacy	Not Covered by Stride[SM] (HMO) in the Coverage Gap. While you are in the Coverage Gap, you pay 37% of the cost for generic drugs.		$0 copayment $0 copayment
Tier 2 Generic **Tier 3 Preferred Brand-Name** **Tier 4 Non-Preferred Brand-Name** **Tier 5 Specialty**	Not Covered by Stride[SM] (HMO) in the Coverage Gap. While you are in the Coverage Gap, you pay 37% of the cost for generic drugs and 25% of the negotiated price (plus a portion of the dispensing fee) for brand name drugs.		
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 $3.40 copayment		
All other Drugs	Greater of 5% coinsurance or $8.50 copayment		

*Please note: Drugs covered by Stride[SM] (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.