Harvard Pilgrim Health Care

2019

"I want a local insurer that understands our needs."

Summary of Benefits

Harvard Pilgrim's Stride℠ (HMO) Medicare Advantage Plan

New Hampshire

Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham, Strafford and Sullivan counties

Y0098_19015_M Accepted

Stride[SM] Basic Rx (HMO), Stride[SM] Value Rx (HMO) and Stride[SM] Value Rx Plus (HMO)

Summary of Benefits

January 1, 2019 – December 31, 2019

This is a summary of drug and health services covered by Stride[SM] Basic Rx (HMO), Stride[SM] Value Rx (HMO) and Stride[SM] Value Rx Plus (HMO) for January 1, 2019 - December 31, 2019.

Harvard Pilgrim is an HMO plan with a Medicare contract. Enrollment in Stride[SM] (HMO) depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. The complete list of services is found in the Evidence of Coverage (EOC) which is available online at www.harvardpilgrim.org/medicare. To order a copy of the Evidence of Coverage, please call our Member Services department (phone number listed on the back cover).

To join Stride[SM] Basic Rx (HMO), Stride[SM] Value Rx (HMO) or Stride[SM] Value Rx Plus (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area for includes the following counties in New Hampshire: Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan.

Stride[SM] Basic Rx (HMO), Stride[SM] Value Rx (HMO) and Stride[SM] Value Rx Plus (HMO) have a network of doctors, hospitals, pharmacies, and other providers. Except in emergency situations, if you use the providers that are not in our network, the plan may not pay for these services.

NOTE:
Services with a [1] may require authorization from the plan.
Services with a [2] may require referral from your doctor.

An individual service will rarely require both authorization and referral, although both may be indicated in this booklet. For more information about whether a particular item or service requires a referral or an authorization, please call the phone number listed on the back cover.

Y0098_19015_M Accepted

Harvard Pilgrim's Covered Services	Stride℠ Basic Rx (HMO)	Stride℠ Value Rx (HMO)	Stride℠ Value Rx Plus (HMO)
Monthly Plan Premium You must continue to pay your Medicare Part B premium.	You pay $0.	You pay $39.	You pay $113.
Deductible	Medical Deductible: You pay $0. Prescription Drug Deductible: You pay a $415 deductible per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2 which are excluded from the deductible.	Medical Deductible: You pay $0. Prescription Drug Deductible: You pay a $270 deductible per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2 which are excluded from the deductible.	Medical Deductible: You pay $0. Prescription Drug Deductible: You pay a $200 deductible per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2 which are excluded from the deductible.
Maximum Out-of-Pocket *(This amount does not include your monthly premiums or any prescription drug costs.)* Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting Medicare- covered hospital and medical services from in-network providers, and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums, as well as your cost-shares for Part D prescription drugs.	$6,700 annually.	$5,600 annually.	$5,000 annually.

Harvard Pilgrim's Covered Services	Stride[SM] Basic Rx (HMO)	Stride[SM] Value Rx (HMO)	Stride[SM] Value Rx Plus (HMO)
Inpatient Hospital Coverage[1] Our plan covers an unlimited number of days for an inpatient hospital stay.	You pay a $370 copayment per day for Days 1-5, then $0 copayment after Day 5.	You pay a $310 copayment per day for Days 1-6, then $0 copayment after Day 6.	You pay a $265 copayment per day for Days 1-6, then $0 copayment after Day 6.
Outpatient Hospital Coverage[1]	You pay a $60 to $350 copayment per visit.	You pay a $60 to $290 copayment per visit.	You pay a $60 to $250 copayment per visit.
Doctor Visits			
○ Primary Care	You pay a $20 copayment per visit.	You pay a $0 copayment per visit.	You pay a $0 copayment per visit.
○ Specialists[2]	You pay a $40 copayment per visit.	You pay a $35 copayment per visit.	You pay a $30 copayment per visit.
○ Chiropractic Care[2]	You pay a $20 copayment per visit.	You pay a $20 copayment per visit.	You pay a $20 copayment per visit.
Medicare-Covered Preventive Care (e.g. flu vaccine, diabetic screenings) Any additional preventive services approved by Medicare during the contract year will be covered.	You pay nothing for most Medicare-covered preventive services. Your cost for some Medicare-covered preventive services will be greater than a $0 copayment.	You pay nothing for most Medicare-covered preventive services. Your cost for some Medicare-covered preventive services will be greater than a $0 copayment.	You pay nothing for most Medicare-covered preventive services. Your cost for some Medicare-covered preventive services will be greater than a $0 copayment.
Annual Routine Physical Exam	You pay nothing.	You pay nothing.	You pay nothing.
Emergency Care If you are admitted to the hospital within 24 hours for the same condition, you pay $0 copayment for the emergency room visit. If you are held for observation, the emergency copayment still applies.	You pay a $90 copayment per visit.	You pay a $90 copayment per visit.	You pay a $90 copayment per visit.

Harvard Pilgrim's Covered Services	Stride[SM] Basic Rx (HMO)	Stride[SM] Value Rx (HMO)	Stride[SM] Value Rx Plus (HMO)
Urgently Needed Services If you are admitted to the hospital within 24 hours for the same condition, you pay $0 copayment for the urgent care visit. If you are held for observation, the urgent care copayment still applies.	You pay a $65 copayment per visit.	You pay a $65 copayment per visit.	You pay a $65 copayment per visit.
Outpatient Diagnostic Services/Labs/ Imaging[1,2]			
○ Diagnostic radiology service such as ultrasounds, MRIs, and CT scans	You pay a $20 to $300 copayment.	You pay a $15 to $200 copayment.	You pay a $10 to $100 copayment.
○ Lab services	You pay a $20 copayment.	You pay a $10 copayment.	You pay a $0 copayment.
○ Diagnostic tests and procedures	You pay a $20 to $60 copayment.	You pay a $10 to $60 copayment.	You pay a $0 to $60 copayment.
○ Outpatient X-rays	You pay a $20 copayment.	You pay a $15 copayment.	You pay a $10 copayment.
○ Therapeutic radiology services (such as radiation treatment for cancer)	You pay a $60 copayment.	You pay a $60 copayment.	You pay a $60 copayment.

Harvard Pilgrim's Covered Services	Stride[SM] Basic Rx (HMO)	Stride[SM] Value Rx (HMO)	Stride[SM] Value Rx Plus (HMO)
Hearing Services			
○ Medicare-covered diagnostic hearing exam[2]	You pay a $40 copayment.	You pay a $35 copayment.	You pay a $30 copayment.
○ Annual routine hearing exam	You pay a $40 copayment.	You pay a $35 copayment.	You pay a $30 copayment.
○ Hearing aids Up to two hearing aids every year. Benefit is limited to the TruHearing Advanced and TruHearing Premium hearing aids, which come in various styles and colors.	You pay a $699 or $999 copayment for each hearing aid.	You pay a $699 or $999 copayment for each hearing aid.	You pay a $699 or $999 copayment for each hearing aid.
Dental Services Dental services are administered by Dental Benefit Providers, Inc. You can see any licensed dentist to receive covered dental services. You may visit our website at www.harvardpilgrim.org/medicare for a listing of participating dentists. If you choose to use a provider who does not participate in our routine dental provider network, you will be subject to: (1) 20% coinsurance for covered services and (2) the difference between the dentist's billed charges and the amount paid by Harvard Pilgrim.	You pay a $40 copayment for Medicare-covered dental services. Preventive dental services not covered.	You pay a $35 copayment for Medicare-covered dental services. After the $35 deductible, you pay a $0 copayment for the following dental services: • Periodic oral exams – two per year • Cleanings (adult prophylaxis) – two per year • Bitewing X-rays – once per year • Complete series or panoramic X-rays – once every three years There is a $500 benefit limit on covered preventive dental services each year.	You pay a $30 copayment for Medicare-covered dental services. After the $35 deductible, you pay a $0 copayment for the following dental services: • Periodic oral exams – two per year • Cleanings (adult prophylaxis) – two per year • Bitewing X-rays – once per year • Complete series or panoramic X-rays – once every three years There is a $500 benefit limit on covered preventive dental services each year.

Harvard Pilgrim's Covered Services	Stride[SM] Basic Rx (HMO)	Stride[SM] Value Rx (HMO)	Stride[SM] Value Rx Plus (HMO)
Vision Services			
○ Medicare-covered vision exam[2] (Refractions are covered when medically necessary to diagnose or treat conditions of the eye.)	You pay a $0 copayment for Diabetic Retinopathy screening. You pay a $40 copayment for all other exams to diagnose and treat diseases and conditions of the eye.	You pay a $0 copayment for Diabetic Retinopathy screening. You pay a $35 copayment for all other exams to diagnose and treat diseases and conditions of the eye.	You pay a $0 copayment for Diabetic Retinopathy screening. You pay a $30 copayment for all other exams to diagnose and treat diseases and conditions of the eye.
○ Medicare-covered eyewear post cataract surgery	You pay a $0 copayment.	You pay a $0 copayment.	You pay a $0 copayment.
○ Annual routine vision exam (Refraction is covered to prescribe corrective eyewear or to screen for conditions of the eye.)	You pay a $0 copayment.	You pay a $0 copayment.	You pay a $0 copayment.
○ Supplemental eyewear	You pay a $0 copayment after reimbursement for one pair of prescription contact lenses, eyeglasses (lenses and frames), lenses only, frames only, or upgrades every year. Please refer to the plan's Wallet Benefit for more information.	You pay a $0 copayment after reimbursement for one pair of prescription contact lenses, eyeglasses (lenses and frames), lenses only, frames only, or upgrades every year. Please refer to the plan's Wallet Benefit for more information.	You pay a $0 copayment after reimbursement for one pair of prescription contact lenses, eyeglasses (lenses and frames), lenses only, frames only, or upgrades every year. Please refer to the plan's Wallet Benefit for more information.

Harvard Pilgrim's Covered Services	Stride[SM] Basic Rx (HMO)	Stride[SM] Value Rx (HMO)	Stride[SM] Value Rx Plus (HMO)
Behavioral Health Services			
o Inpatient visit[1] Our plan covers an unlimited number of days for an inpatient hospital stay	You pay a $370 copayment per day for Days 1-4, then $0 copayment after Day 4.	You pay a $310 copayment per day for Days 1-5, then $0 copayment after Day 5.	You pay a $265 copayment per day for Days 1-6, then $0 copayment after Day 6.
o Outpatient visit with a psychiatrist or licensed provider	You pay a $40 copayment per individual or group therapy visit.	You pay a $35 copayment per individual or group therapy visit.	You pay a $30 copayment per individual or group therapy visit.
Skilled Nursing Facility (SNF)[1] Our plan covers up to 100 days per admission in a SNF. A hospital stay prior to SNF admission is not required.	You pay a $0 copayment per day for Days 1-20, then $172 copayment per day for Days 21-100.	You pay a $0 copayment per day for Days 1-20, then $165 copayment per day for Days 21-100.	You pay a $0 copayment per day for Days 1-20, then $155 copayment per day for Days 21-100.
Rehabilitation Services[1,2]			
o Occupational therapy visit	You pay a $30 copayment.	You pay a $25 copayment.	You pay a $25 copayment.
o Physical therapy and speech language therapy visit	You pay a $30 copayment.	You pay a $25 copayment.	You pay a $25 copayment.
o Cardiac rehabilitation	You pay a $30 copayment.	You pay a $25 copayment.	You pay a $25 copayment.
Ambulance[1]	You pay a $250 copayment for one-way Medicare-covered ambulance transport.	You pay a $250 copayment for one-way Medicare-covered ambulance transport.	You pay a $250 copayment for one-way Medicare-covered ambulance transport.

Harvard Pilgrim's Covered Services	Stride[SM] Basic Rx (HMO)	Stride[SM] Value Rx (HMO)	Stride[SM] Value Rx Plus (HMO)
Transportation[1] By way of wheelchair van. Covered when medically necessary, instead of ambulance.	You pay a $60 copayment per one-way trip to plan-approved locations.	You pay a $60 copayment per one-way trip to plan-approved locations.	You pay a $60 copayment per one-way trip to plan-approved locations.
Medicare Part B Drugs[1]	You pay 20% of the total cost for chemotherapy drugs. You pay 20% of the total cost for other Part B drugs.	You pay 20% of the total cost for chemotherapy drugs. You pay 20% of the total cost for other Part B drugs.	You pay 20% of the total cost for chemotherapy drugs. You pay 20% of the total cost for other Part B drugs.
Foot Care (podiatry services)[2]			
○ Foot exams and treatment	You pay a $40 copayment.	You pay a $35 copayment.	You pay a $30 copayment.
○ Routine foot care (May be covered if you have diabetes-related nerve damage and/or meet certain conditions.)	You pay a $40 copayment.	You pay a $35 copayment.	You pay a $30 copayment.
Durable Medical Equipment (DME) and Related Supplies[1]			
○ Durable Medical Equipment (e.g. wheelchairs, oxygen)	You pay 20% of the total cost.	You pay 20% of the total cost.	You pay 20% of the total cost.
○ Prosthetics (e.g. braces, artificial limbs)	You pay 20% of the total cost.	You pay 20% of the total cost.	You pay 20% of the total cost.
○ Diabetes supplies (Preferred brand is Abbott Diabetes Care.)	You pay a $0 copayment.	You pay a $0 copayment.	You pay a $0 copayment.

Harvard Pilgrim's Covered Services	Stride[SM] Basic Rx (HMO)	Stride[SM] Value Rx (HMO)	Stride[SM] Value Rx Plus (HMO)
Wellness Programs o Acupuncture Visits o Alternative Therapies o Fitness Membership o Massage Therapy Practitioners must be licensed, if applicable, in the state where they provide services.	You pay a $0 copayment after reimbursement. Please refer to the plan's Wallet Benefit for more information. Alternative Therapies are holistic medicine, bodywork, and mind/body therapies. Limitations/exclusions apply.	You pay a $0 copayment after reimbursement. Please refer to the plan's Wallet Benefit for more information. Alternative Therapies are holistic medicine, bodywork, and mind/body therapies. Limitations/exclusions apply.	You pay a $0 copayment after reimbursement. Please refer to the plan's Wallet Benefit for more information. Alternative Therapies are holistic medicine, bodywork, and mind/body therapies. Limitations/exclusions apply.
Over-The-Counter Benefit Please contact the plan or visit our website for specific instructions on using this benefit and for our list of covered Over-the-Counter items.	Our plan provides a $150 annual over-the-counter allowance, which may not exceed $50 per month.	Our plan provides a $200 annual over-the-counter allowance, which may not exceed $50 per month.	Our plan provides a $250 annual over-the-counter allowance, which may not exceed $50 per month.
Outpatient Substance Abuse	You pay a $40 copayment.	You pay a $35 copayment.	You pay a $30 copayment.
Partial Hospitalization[1]	You pay a $55 copayment per day.	You pay a $55 copayment per day.	You pay a $55 copayment per day.
Wallet Benefit Covers the cost of any of the following items or services: o Acupuncture Visits o Alternative Therapies (Limitations / exclusions apply) o Massage Therapy o Supplemental Eyewear	Plan includes a $250 annual reimbursement amount.	Plan includes a $325 annual reimbursement amount.	Plan includes a $400 annual reimbursement amount.

PRESCRIPTION DRUG BENEFITS			
Part D Prescription Drug Stage	**Stride SM Basic Rx (HMO)**	**Stride SM Value Rx (HMO)**	**Stride SM Value Rx Plus (HMO)**
Deductible	During this stage, you pay the full cost of your Tier 3, 4 and 5 drugs. You stay in this stage until you have paid $415 for your Tier 3, 4 and 5 drugs	During this stage, you pay the full cost of your Tier 3, 4 and 5 drugs. You stay in this stage until you have paid $270 for your Tier 3, 4 and 5 drugs	During this stage, you pay the full cost of your Tier 3, 4 and 5 drugs. You stay in this stage until you have paid $200 for your Tier 3, 4 and 5 drugs
Cost-sharing may change depending on the pharmacy you chose and when you enter a new phase of the Part D benefit.			
Initial Coverage	After you pay your yearly deductible, you pay the copayments or coinsurance 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. You may get your drugs at pharmacies in our network, including retail and mail order pharmacies.		
Coverage Gap	Most Medicare drug plans have a coverage gap. The coverage gap begins after the total yearly drug cost (what our plan has paid and what you have paid) reaches $3,820. During this stage, you pay 25% of the price for brand-name drugs (plus a portion of the dispensing fee) and 37% of the price for generic drugs until your costs total $5,100 and the coverage gap ends. Not everyone will enter the coverage gap.	Most Medicare drug plans have a coverage gap. The coverage gap begins after the total yearly drug cost (what our plan has paid and what you have paid) reaches $3,820. During this stage, you pay 25% of the price for brand-name drugs (plus a portion of the dispensing fee) and 37% of the price for generic drugs until your costs total $5,100 and the coverage gap ends. Not everyone will enter the coverage gap.	Most Medicare drug plans have a coverage gap. The coverage gap begins after the total yearly drug cost (what our plan has paid and what you have paid) reaches $3,820. Under this plan only, you will continue to pay a $0 copayment for Tier 1 drugs from retail or mail-order network pharmacies during the coverage gap. Otherwise, you pay 25% of the price for brand-name drugs (plus a portion of the dispensing fee) and 37% of the price for generic drugs until your costs total $5,100 and the coverage gap ends. Not everyone will enter the coverage gap.
Catastrophic Coverage	After your out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100 you pay the greater of either: – coinsurance that is 5% of the cost of the drug, or – $3.40 for a generic drug or a drug that is treated like a generic and $8.50 for all other drugs. Our plan pays the rest of the cost.		

Initial Coverage — Retail Cost-Shares (30-day supply)

Tier	Stride[SM] Basic Rx (HMO)	Stride[SM] Value Rx (HMO)	Stride[SM] Value Rx Plus (HMO)
Tier 1: Preferred Generic	You pay a $0 copayment	You pay a $0 copayment	You pay a $0 copayment
Tier 2: Generic	You pay a $15 copayment	You pay a $10 copayment	You pay a $10 copayment
Tier 3: Preferred Brand-Name	You pay a $47 copayment	You pay a $47 copayment	You pay a $47 copayment
Tier 4: Non-Preferred Brand-Name	You pay a $100 copayment	You pay a $100 copayment	You pay a $100 copayment
Tier 5: Specialty	You pay 25% of the total cost	You pay 27% of the total cost	You pay 29% of the total cost

Initial Coverage — Mail Order Cost-Shares (90-day supply)

Tier	Stride[SM] Basic Rx (HMO)	Stride[SM] Value Rx (HMO)	Stride[SM] Value Rx Plus (HMO)
Tier 1: Preferred Generic	You pay a $0 copayment	You pay a $0 copayment	You pay a $0 copayment
Tier 2: Generic	You pay a $30 copayment	You pay a $20 copayment	You pay a $20 copayment
Tier 3: Preferred Brand-Name	You pay a $94 copayment	You pay a $94 copayment	You pay a $94 copayment
Tier 4: Non-Preferred Brand-Name	You pay a $250 copayment	You pay a $250 copayment	You pay a $250 copayment
Tier 5: Specialty	You pay 25% of the total cost	You pay 27% of the total cost	You pay 29% of the total cost

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.
You may get a 30-day supply of drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.

More information

To learn more about Harvard Pilgrim's Stride℠ (HMO) or to view plan documents, please visit our website or call us. Our contact information is below.

Harvard Pilgrim's Stride℠ (HMO)	Current members: Prospective members: Website: Hours of operation:	1-888-609-0692 (TTY: 711) 1-877-431-4742 (TTY: 711) harvardpilgrim.org/medicare October 1 – March 31, we're available 8 a.m.- 8 p.m., seven days a week. April 1 – September 30, we're available Monday – Friday, 8 a.m.- 8 p.m.
Provider and Pharmacy Directory	harvardpilgrim.org/medicare	
Formulary (List of Covered Drugs)	harvardpilgrim.org/medicare We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.	
Original Medicare More information about coverage and costs of Original Medicare	"Medicare & You" handbook View online at http://www.medicare.gov Get a copy by calling 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week TTY users should call 1-877-486-2048.	

This document is available in other formats such as Braille, large print or audio.

This information is not a complete description of benefits. Call Member Services at 1-888-609-0692 (TTY: 711) for more information.

Harvard Pilgrim Health Care

For more information about **Stride℠ (HMO)**, call:

Prospective Members:	1-866-256-5347
For TTY service, call	711
Current Members:	1-888-609-0692
For TTY service, call	711

Hours of operation:

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.

Or visit us online:
hpforlife.org

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