Harvard Pilgrim Health Care

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

Annual Notice of Changes
Basic Rx

New Hampshire

Y0098_19020_M

Stride[SM] Basic Rx (HMO) offered by Harvard Pilgrim Health Care of New England, Inc.

Annual Notice of Changes for 2019

You are currently enrolled as a member of Stride[SM] Basic Rx (HMO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1 and 2 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost-sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2019 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 and 1.4 for information about our Provider and Pharmacy Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you want to **keep** Stride[SM] Basic Rx (HMO), you don't need to do anything. You will stay in Stride[SM] Basic Rx (HMO).

  To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2018**

- If you **don't join another plan by December 7, 2018**, you will stay in Stride[SM] Basic Rx (HMO).
- If you join another plan by December 7, 2018, your new coverage will start on January 1, 2019.

Additional Resources

- Please contact our Member Services number at 1-888-609-0692 for additional information. (TTY users should call 711.) Hours are October 1 - March 31, from 8 a.m. to 8 p.m., 7 days a week and April 1 - September 30, from 8 a.m. to 8 p.m., Monday through Friday.
- If needed, we can also provide you information in large print or other alternate formats.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Stride[SM] Basic Rx (HMO)

- Harvard Pilgrim is an HMO plan with a Medicare contract. Enrollment in Stride[SM] Basic Rx (HMO) depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Harvard Pilgrim Health Care of New England, Inc. When it says "plan" or "our plan," it means Stride[SM] Basic Rx (HMO).

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Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Stride[SM] Basic Rx (HMO) in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the *Evidence of Coverage* to see if other benefit or cost changes affect you. A copy of the Evidence of Coverage is located on our website at www.harvardpilgrim.org/medicare. You may also call Member Services to ask us to mail you an Evidence of Coverage.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$6,700	$6,700
Doctor office visits	Primary care visits: $20 copayment per visit. Specialist visits: $40 copayment per visit.	Primary care visits: $20 copayment per visit. Specialist visits: $40 copayment per visit.
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	$360 copayment per day for Days 1-5, then $0 copayment after Day 5.	$370 copayment per day for Days 1-5, then $0 copayment after Day 5.

Cost	2018 (this year)	2019 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $405 Cost-share during the Initial Coverage Stage: • Drug Tier 1: $0 copayment • Drug Tier 2: $15 copayment • Drug Tier 3: $47 copayment • Drug Tier 4: $100 copayment • Drug Tier 5: 25% of the total cost	Deductible: $415 Cost-share during the Initial Coverage Stage: • Drug Tier 1: $0 copayment • Drug Tier 2: $15 copayment • Drug Tier 3: $47 copayment • Drug Tier 4: $100 copayment • Drug Tier 5: 25% of the total cost

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving "Extra Help" with your prescription drug costs.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2018 (this year)	2019 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700	$6,700 Once you have paid $6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider and Pharmacy Directory* is located on our website at www.harvardpilgrim.org/medicare. You may also call Member Services for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*. **Please review the 2019 *Provider and Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated *Provider and Pharmacy Directory* is located on our website at www.harvardpilgrim.org/medicare. You may also call Member Services for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*. **Please review the 2019 *Provider and Pharmacy Directory* to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2019 Evidence of Coverage.*

Cost	2018 (this year)	2019 (next year)
Acupuncture	Not Covered	Our plan provides a $250 annual reimbursement that may be used towards Acupuncture visits. Practitioners must be licensed, if applicable, in the state where they provide services. Please see the Wallet Benefit later in this section.
Alternative Therapies	Not Covered	Our plan provides a $250 annual reimbursement that may be used toward Alternative Therapies. Practitioners must be licensed, if applicable, in the state where they perform services. Please see the Wallet Benefit later in this section.
Ambulatory Surgical Services	20% of the total cost per visit for Medicare-covered services.	$350 copayment for Medicare-covered services.
Dialysis Services	20% of the total cost for Medicare-covered services.	$30 copayment per visit for Medicare-covered services.
Emergency Care	$80 copayment for Medicare-covered services.	$90 copayment for Medicare-covered services.

Cost	2018 (this year)	2019 (next year)
Eyewear	Our plan provides a $150 reimbursement every two years for prescription eyewear and/or upgrades not covered by Medicare.	Our plan provides a $250 annual reimbursement that may be used toward one pair of corrective eyewear, specifically: • Contact lenses, or • Eyeglasses (lenses and frames), or • Eyeglass lenses only, or • Eyeglass frames only, or • Upgrades for Medicare-covered eyewear (e.g., post-cataract surgery). Please see the Wallet Benefit later in this section.
Fitness Benefit	Our plan provides a $200 annual reimbursement for Fitness Club membership.	Our plan provides a $250 annual reimbursement that may be used toward a membership. Facilities that offer Tai Chi or Qi Gong may qualify for coverage. Please see the Wallet Benefit later in this section.
Hearing Exams	$45 copayment for annual routine hearing exam.	$40 copayment for annual routine hearing exam.
Inpatient Hospital Acute	$360 copayment per day for Days 1-5, then $0 copayment after Day 5.	$370 copayment per day for Days 1-5, then $0 copayment after Day 5.
Inpatient Hospital Psychiatric	$320 copayment per day for Days 1-5, then $0 copayment after Day 5.	$370 copayment per day for Days 1-4, then $0 copayment after Day 4.
Kidney Disease Education Services	20% of the total cost for Medicare-covered services.	$0 copayment for Medicare-covered services.

Cost	2018 (this year)	2019 (next year)
Massage Therapy	Not Covered	Our plan provides a $250 annual reimbursement that may be used toward Massage Therapy. Practitioners must be licensed, if applicable, in the state where they perform services. Please see the Wallet Benefit later in this section.
Outpatient Blood Services	20% of the total cost for Medicare-covered services.	$0 copayment for Medicare-covered services.
Outpatient Diagnostic Procedures/ Tests/Lab Services	$20 copayment for Medicare-covered services.	$20 to $60 copayment for Medicare-covered non-radiological diagnostic procedures, tests and lab services.
Outpatient Diagnostic/ Therapeutic Radiology Services	20% of the total cost for Medicare-covered services.	$20 to $300 copayment for Medicare-covered services.
Outpatient Hospital Services	20% of the total cost per visit for Medicare-covered services.	$60 to $350 copayment for Medicare-covered services.
Outpatient Observation Services	$0 copayment per visit for Medicare-covered services.	$360 copayment per visit for Medicare-covered services.
Skilled Nursing Facility (SNF)	$0 copayment per day for Days 1-20, then $160 per day for Days 21-100.	$0 copayment per day for Days 1-20, then $172 copayment per day for Days 21-100.

Cost	2018 (this year)	2019 (next year)
Transportation Services	Not Covered	Unlimited trips to plan-approved locations via wheelchair van when medically appropriate, instead of ambulance. $60 copayment per one-way trip. Authorization is required.
Urgently Needed Services	$45 copayment for Medicare-covered urgently needed services.	$65 copayment for Medicare-covered urgently needed services.

Wallet Benefit	Not Covered	Our plan provides a $250 annual reimbursement that may be used to cover the cost of any of the following items or services:
		
		• Acupuncture Visits
		• Alternative Therapies:
		  o Holistic Medicine
		  o Bodywork
		  o Mind/Body Therapies
		• Eyewear or upgrades not covered by Medicare
		• Fitness Membership, including Tai Chi & Gong
		• Massage Therapy

Worldwide Emergency/ Urgent Coverage	$80 copayment for worldwide emergency or urgent coverage.	$90 copayment for worldwide emergency or urgent coverage.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our Drug List is located on our website at www.harvardpilgrim.org/medicare. You may also call Member Services to ask us to mail you a Formulary or "Drug List".

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. For 2019, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days supply provided in all other cases: 30-day supply of medication rather than the amount provided in 2018 (98-days of medication). (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you were approved for a formulary exception this year, we will honor that exception through the date specified on the letter we sent you when your request was originally approved.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

Starting in 2019, before we make changes during the year to our Drug List that require us to provide you with advance notice when you are taking a drug, we will provide you with notice of those changes 30, rather than 60, days before they take place. Or we will give you a 30-day, rather than a 60-day, refill of your brand name drug at a network pharmacy. We will provide this notice before, for instance, replacing a brand name drug on the Drug List with a generic drug or making changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about the changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and haven't received this insert by September 30, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in Section 7.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.). A copy of our Evidence of Coverage is located on our website at www.harvardpilgrim.org/medicare. You may also call Member Services to ask us to mail you the Evidence of Coverage.

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3, Tier 4, and Tier 5 drugs until you have reached the yearly deductible.	The deductible is $405. During this stage, you pay $0 cost-sharing for drugs on Tier 1, $15 cost sharing on Tier 2 drugs, and the full cost of drugs on Tier 3, 4 and 5 until you have reached the yearly deductible.	The deductible is $415. During this stage, you pay $0 cost-sharing for drugs on Tier 1, $15 cost-sharing for drugs on Tier 2 and the full cost of drugs on Tier 3, 4 and 5 until you have reached the yearly deductible.

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2018 (this year)	2019 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply; or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1: Preferred Generic Drugs:** You pay a $0 copayment per prescription. **Tier 2: Generic Drugs:** You pay a $15 copayment per prescription. **Tier 3: Preferred Brand-Name Drugs:** You pay a $47 copayment per prescription. **Tier 4: Non-Preferred Brand-Name Drugs:** You pay a $100 copayment per prescription. **Tier 5: Specialty Drugs:** You pay 25% of the total cost. Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1: Preferred Generic Drugs:** You pay a $0 copayment per prescription. **Tier 2: Generic Drugs:** You pay a $15 copayment per prescription. **Tier 3: Preferred Brand-Name Drugs:** You pay a $47 copayment per prescription. **Tier 4: Non-Preferred Brand-Name Drugs:** You pay a $100 copayment per prescription. **Tier 5: Specialty Drugs:** You pay 25% of the total cost. Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Changes	2018 (this year)	2019 (next year)
Chiropractic Services	Authorization may be required for Medicare-covered services.	Authorization not required for Medicare-covered services.
Comprehensive Dental	Authorization may be required for Medicare-covered services.	Authorization is required when Medicare-covered services must be provided in a hospital setting, either inpatient or outpatient, due to medical necessity.
Outpatient Blood Services	Authorization may be required for Medicare-covered services.	Authorization not required for Medicare-covered services.
Podiatry Services	Authorization may be required for Medicare-covered services.	Authorization not required for Medicare-covered services.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Stride[SM] Basic Rx (HMO)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2019.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2019 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Harvard Pilgrim offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Stride[SM] Basic Rx (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Stride[SM] Basic Rx (HMO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2019.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2019, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2019. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In New Hampshire, the SHIP is called New Hampshire ServiceLink Resource Center.

New Hampshire ServiceLink Resource Center is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. New Hampshire ServiceLink Resource Center counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call New Hampshire ServiceLink Resource Center at 1–866–634–9412. You can learn more about New Hampshire ServiceLink Resource Center by visiting their website (www.servicelink.nh.gov).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the New Hampshire ADAP program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 603-271-4502 or 800-852-3345, ext. 4502.

SECTION 7 Questions?

Section 7.1 – Getting Help from Stride[SM] Basic Rx (HMO)

Questions? We're here to help. Please call Member Services at 1-888-609-0692. (TTY only, call 711). We are available for phone calls October 1 – March 31, from 8 a.m. to 8 p.m., 7 days a week and April 1 - September 30, from 8 a.m. to 8 p.m., Monday through Friday. Calls to these numbers are free.

Read your 2019 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2019. For details, look in the 2019 *Evidence of Coverage* for Stride[SM] Basic Rx (HMO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of our Evidence of Coverage is located on our website at www.harvardpilgrim.org/medicare. You may also call Member Services to ask us to mail you the Evidence of Coverage.

Visit our Website

You can also visit our website at www.harvardpilgrim.org/medicare . As a reminder, our website has the most up-to-date information about our provider network (*Provider and Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (https://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on "Find health & drug plans").

Read *Medicare & You 2019*

You can read the *Medicare & You 2019* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or 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.