Harvard Pilgrim Health Care

Stride[SM] (HMO) Medicare Advantage Plan Comparison

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, Strafford and Sullivan	**$44** Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham and Sullivan **$49** Strafford	**$54** Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham and Sullivan **$59** Strafford	**$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	$20 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 $20 copayment for lab services $270 copayment for MRI/CT scans	$10 copayment for X-ray $10 copayment for lab services $200 copayment for MRI/CT scans	$15 copayment for X-ray $15 copayment for lab services $150 copayment for MRI/CT scans	$15 copayment for X-ray $15 copayment for lab services $150 copayment for MRI/CT scans
Medicare Covered Chemotherapy Drugs & Other Part B Prescription Drugs	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Outpatient Surgery	$270 copayment for each Medicare-approved surgery	$200 copayment for each Medicare-approved surgery	$200 copayment for each Medicare-approved surgery	$250 copayment for each Medicare-approved 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 1-4, $370 copayment each day	Days 1-5, $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, $178 copayment per day	Days 1-20, $0 copayment per day Days 21-100, $178 copayment per day	Days 1-20, $0 copayment per day Days 21-100, $178 copayment per day*	Days 1-20, $0 copayment per day Days 21-100, $178 copayment per day
Durable Medical Equipment	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
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 of the emergency or urgent care visit	$90 copayment per visit waived if admitted for inpatient care or outpatient observation within 24 hours of the emergency or urgent care visit	$90 copayment per visit waived if admitted for inpatient care or outpatient observation within 24 hours of the emergency or urgent care visit	$90 copayment per visit waived if admitted for inpatient care or outpatient observation within 24 hours of the emergency or urgent care visit
Urgent Care	$65 copayment per visit	$65 copayment per visit	$65 copayment per visit	$65 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 copays in network or out-of-network—and no deductible	$500 annual limit Periodontal exams & cleanings $0 copays in network or out-of-network—and no deductible	$500 annual limit Periodontal exams & cleanings $0 copays in network or out-of-network—and no deductible	$500 annual limit Periodontal exams & cleanings $0 copays 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 and more	Up to $325 reimbursement annually for qualified health and wellness expenses including a fitness tracker, fitness membership, eyewear and more	Up to $400 reimbursement annually for qualified health and wellness expenses including a fitness tracker, fitness membership, eyewear and more	Up to $400 reimbursement annually for qualified health and wellness expenses including a fitness tracker, fitness membership, eyewear and more

* 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 Stride[SM] (HMO) at **(866) 256-5365**, **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

Stride^{SM} (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	**$435** 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$4,020. 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 90-Day Supply-Mail Order Pharmacy	$0 copayment $0 copayment	$0 copayment $0 copayment	$0 copayment $0 copayment	$0 copayment $0 copayment
Tier 2 Generic 30-Day Supply-Retail Pharmacy 90-Day Supply-Mail Order Pharmacy	$15 copayment $30 copayment	$10 copayment $20 copayment	$10 copayment $20 copayment	$10 copayment $20 copayment
Tier 3 Preferred Brand-Name 30-Day Supply-Retail Pharmacy 90-Day Supply-Mail Order Pharmacy	$47 copayment $94 copayment	$47 copayment $94 copayment	$47 copayment $94 copayment	$47 copayment $94 copayment
Tier 4 Non-Preferred Brand-Name 30-Day Supply-Retail Pharmacy 90-Day Supply-Mail Order Pharmacy	$100 copayment $250 copayment	$100 copayment $250 copayment	$100 copayment $250 copayment	$100 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 $6,350* for covered Part D drugs.			
Tier 1 Preferred Generic 30-Day Supply-Retail Pharmacy 90-Day Supply-Mail Order Pharmacy	$0 copayment $0 copayment	$0 copayment $0 copayment	$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 $3.60 copayment			
All other Drugs	Greater of 5% coinsurance or $8.95 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.

Harvard Pilgrim Health Care

Stride^{SM} (HMO) Medicare Advantage Plan Prescription Drug Benefits

When you join a Stride^{SM} (HMO) plan, your Part D Prescription Drug Coverage is included in your monthly premium. The chart inside explains your costs for covered Part D drugs only. You have the option to use our network retail pharmacies or save money by using our convenient Mail Order Pharmacy program with free shipping directly to your home. Coverage for Part B drugs are included in your Part B Medical benefits.

Harvard Pilgrim uses a list of Part D prescription drugs (generic & brand) called a Formulary. Your prescription drugs must be included in our Formulary to be covered.

Visit us online at **hpforlife.org**
or call **(866) 256-5365 TTY: 711**
Oct 1 - March 31, 8am – 8pm, 7 days a week;
April 1 - Sept. 30, 8am – 8pm, Mon – Fri

Harvard Pilgrim Health Care

Harvard Pilgrim is an HMO/HMO-POS plan with a Medicare contract. Enrollment in Stride^{SM} (HMO) depends on contract renewal. Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care and Harvard Pilgrim Health Care of New England. This information is not a complete description of benefits. Call **(866) 256-5350 (TTY: 711)** for more information.

Harvard Pilgrim Health Care complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al **(844) 299-4789** (**TTY: 711**).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para **(844) 299-4789** (**TTY: 711**).

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"Choice is important to me"

Stride^{SM} (HMO) Medicare Advantage Plan

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