Harvard Pilgrim Health Care

Commonwealth of Massachusetts
Group Insurance Commission

Summary of Benefits – July 1, 2019 - June 30, 2020

Independence℠ Plan POS

	In-Network	Out-of-Network*
Deductible	$500 per Member/$1,000 per Family	$500 per Member/$1,000 per Family
Out-of-Pocket Maximum	$5,000 per Member/$10,000 per Family (All in-network medical, prescription drug and mental health Copays and Deductibles apply to the out-of-pocket maximum.)	$5,000 per Member/$10,000 per Family (excluding Coinsurance for Skilled Nursing Facility Care)
Outpatient Care		
Primary Care Provider Visits	$10/$20/$40	Deductible, then 20% coinsurance
Specialist Visits	**Tier 1 Copayment:** $30 **Tier 2 Copayment:** $60 **Tier 3 Copayment:** $75	Deductible, then 20% coinsurance
Emergency Room Copayment – waived if admitted	$100 Copayment, then Deductible	$100 Copayment, then Deductible
Mammograms and Pap smears	No charge	Deductible, then 20% coinsurance
Administration of Allergy Injections	Deductible, then no charge	Deductible, then 20% coinsurance
High-Tech Radiology (e.g., MRI, PET and CT scans)	$100 Copayment per scan, then Deductible	Deductible, then 20% coinsurance
Hospital Services		
Inpatient Semi-Private Room and Board and Physicians' Services **Inpatient copayment:** • **Tier 1 = $275** • **Tier 2 = $500** • **Tier 3 = $1,500**	Subject to Hospital Inpatient Copayment, then Deductible (Limited to one Copayment per quarter)	Deductible, then 20% coinsurance
Surgical Day Care	$250 Copayment per visit, then Deductible. **New!** $150 copayment, then Deductible for eye and gastrointestinal procedures performed at ambulatory surgical centers. (There is a maximum of four Surgical Day Care Copayments per Member per plan year.)	Deductible, then 20% coinsurance
Hospital Outpatient Services (e.g., lab tests, anesthesia and X-rays)	Deductible, then no charge	Deductible, then 20% coinsurance
Skilled Nursing Facility Care Services up to 45 days per plan year	20% of Reasonable Charges (Coinsurance) after the Deductible has been met	Deductible, then 20% coinsurance
Inpatient Rehabilitation Services	Deductible, then no charge	Deductible, then 20% coinsurance
Prescription Drug Benefit		
The GIC provides prescription drug coverage through Express Scripts. Visit express-scripts.com/gicrx or call (855) 283-7679 for more information.	Deductible: $100 per Member, $200 per Family, then: In-Network Retail Pharmacy (up to 30-day supply): $10/$30/$65 Mail Order (up to 90-day supply): $25/$75/$165	
Other Services		
Durable Medical Equipment including Prosthetics	Deductible, then no charge	Deductible, then 20% coinsurance

*Please note that non-participating providers may bill you for the differences between their charges and the amount Harvard Pilgrim pays for covered services.

Continued

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Summary of Benefits – July 1, 2019 - June 30, 2020

Independence℠ Plan POS

	In-Network	Out-of-Network*
Other Services (continued)		
Physical and Occupational Therapies up to 90 consecutive days per illness or injury	$20 Copayment	Deductible, then 20% coinsurance
Chiropractic Care 20 visits per plan year	$20 Copayment	Deductible, then 20% coinsurance
Bi-annual Routine Vision Exam – covered once every 24 months A $20 copayment applies when you have this exam with a participating optometrist.	Tier 1 Copayment: $30 Tier 2 Copayment: $60 Tier 3 Copayment: $75	Deductible, then 20% coinsurance
Ambulance	Deductible, then no charge	Deductible, then 20% coinsurance
Behavioral Health		
Office Visits	**Individual:** $10 per visit **Group:** $15 per visit	Deductible, then 20% coinsurance
Inpatient – General Hospital (semi-private room and board and special services)	$275 Copayment per admission (Limited to one Copayment per quarter)	Deductible, then 20% coinsurance
Inpatient Mental Hospital Facility	$275 Copayment per admission (Limited to one Copayment per quarter)	Deductible, then 20% coinsurance
Inpatient Substance Abuse Facility	$275 Copayment per admission (Limited to one Copayment per quarter)	Deductible, then 20% coinsurance

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