Harvard Pilgrim Health Care

Commonwealth of Massachusetts
Group Insurance Commission

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

Primary Choice℠ HMO

Deductible	$400 per Member/$800 per Family
Out-of-Pocket Maximum	$5,000 per Member/$10,000 per Family (All medical, prescription drug and mental health Copays and Deductibles apply to the out-of-pocket maximum.)
Outpatient Care	
Primary Care Provider Visits	$20 Copayment
Specialist Visits	**Tier 1 Copayment:** $30 / **Tier 2 Copayment:** $60
Emergency Room Copayment – waived if admitted	$100 Copayment, then Deductible
Mammograms and Pap smears	No charge
Administration of Allergy Injections	Deductible, then no charge
High-Tech Radiology (e.g., MRI, PET and CT scans)	$100 Copayment per scan, then Deductible
Hospital Services	
Inpatient Semi-Private Room and Board and Physicians' Services **Inpatient copayment: Tier 1 =** $275 **/ Tier 2 =** $500	Subject to Hospital Inpatient Copayment, then Deductible (Limited to one Copayment per quarter)
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.)
Hospital Outpatient Services (e.g., lab tests, anesthesia and X-rays)	Deductible, then no charge
Skilled Nursing Facility Care Services up to 45 days per plan year	Deductible, then 20% coinsurance
Inpatient Rehabilitation Services	Deductible, then no charge
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
Physical and Occupational Therapies up to 90 consecutive days per illness or injury	$20 Copayment
Chiropractic Care – 20 visits per plan year	$20 Copayment
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
Ambulance	Deductible, then no charge
Behavioral Health	
Office Visits	**Individual:** $20 per visit / **Group:** $15 per visit
Inpatient – General Hospital (semi-private room and board and special services)	$275 Copayment per admission (Limited to one Copayment per quarter)
Inpatient Mental Hospital Facility	$275 Copayment per admission (Limited to one Copayment per quarter)
Inpatient Substance Abuse Facility	$275 Copayment per admission (Limited to one Copayment per quarter)