myBenefits



Review Choose Enroll

Brigham and Women's Faulkner Hospital

2020 Medical Plan Comparison Chart for Post-Tax Nurses*

*represented by collective bargaining agreement

BRIGHAM HEALTH
BWH BRIGHAM AND WOMEN'S Faulkner Hospital

PARTNERS HEALTHCARE | FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL AND MASSACHUSETTS GENERAL HOSPITAL

This chart is only a summary. For details, limitations, and exclusions, please contact the HR Support Center at **1-833-AskmyHR (1-833-275-6947)** for the specific plan's benefit description.

	ALLWAYS HEALTH PARTNERS
General Provisions	
Annual Deductible (individual/family)	None
The Plan's Coinsurance	Covered in Full
Medical Out-of-Pocket Maximum (individual/family)	$2,500/$5,000
Pre-Admission Certification	Required
Primary Care Physician	Required
Maximum Lifetime Benefit	Unlimited
Inpatient Medical and Surgical Services	
Semiprivate Room and Ancillary Services	Covered in Full
Inpatient Physician	Covered in Full
Inpatient Mental Health	Covered in Full
Inpatient Substance Use	Covered in Full
Surgeon/Anesthesia	Covered in Full
Private Duty Nursing	Not Covered
Outpatient Covered Services	
Physician Visits	Covered in Full
Routine Physicals/Other Preventive Care	Covered in Full
Hospital Outpatient	Covered in Full
Hospital Emergency Room	$25 co-pay (waived if admitted)
Second Surgical Opinion	Covered in Full
Outpatient Surgery	Covered in Full
Pre-Hospital Admission Testing/Labs	Covered in Full
Routine Pediatric Care	Covered in Full
Immunizations and Inoculations (adult)	Covered in Full
Pap Smear	Covered in Full
Routine Mammogram (one baseline mammogram between ages 35–39; one mammogram per year after age 40)	Covered in Full
Hearing Exams	Covered in Full
Hearing Aids and Batteries	Not covered (except for children under age 22)[1]
Diagnostic X-Ray and Lab Services	Covered in Full
Physical Therapy	100% up to 90 consecutive days per condition
Mental Health and Substance Use Disorders – Outpatient	Covered in Full
Durable Medical Equipment	Plan pays 80% coverage
Ambulance Service	Covered in Full
Allergy Testing and Treatment	Covered in Full
Maternity Coverage	
In-Hospital (Delivery)	Covered in Full
Out-of-Hospital (prenatal care)	Covered in Full
Other Services	
Skilled Nursing Facilities	Covered in Full (up to 100 days per calendar year)
Home Health Services	Covered in Full
Hospice Care	Covered in Full, when approved
Cardiac Rehabilitation	Covered in Full
Chiropractic Services	Not covered
Podiatrist Services (limited services only)	100%

[1] Hearing aids are covered up to age 22 under the state mandate. Coverage is $2,000 per ear every 36 months.

	TUFTS TOTAL HEALTH PLAN
General Provisions	
Annual Deductible (individual/family)	None
The Plan's Coinsurance	Covered in Full
Medical Out-of-Pocket Maximum (individual/family)	None
Pre-Admission Certification	Required
Primary Care Physician	Required
Maximum Lifetime Benefit	Unlimited
Inpatient Medical and Surgical Services	
Semiprivate Room and Ancillary Services	Covered in Full
Inpatient Physician	Covered in Full
Inpatient Mental Health	Covered in Full
Inpatient Substance Use	Covered in Full
Surgeon/Anesthesia	Covered in Full
Private Duty Nursing	Not Covered
Outpatient Covered Services	
Physician Visits	$10 co-pay
Routine Physicals/Other Preventive Care	Covered in Full
Hospital Outpatient	Covered in Full
Hospital Emergency Room	$50 co-pay (waived if admitted)
Second Surgical Opinion	Covered in Full
Outpatient Surgery	Covered in Full
Pre-Hospital Admission Testing/Labs	Covered in Full
Routine Pediatric Care	Covered in Full
Immunizations and Inoculations (adult)	Covered in Full
Pap Smear	Covered in Full
Routine Mammogram (one baseline mammogram between ages 35–39; one mammogram per year after age 40)	Covered in Full
Hearing Exams	$10 co-pay
Hearing Aids and Batteries	Not covered (except for children under age 22; see Durable Medical Equipment)
Diagnostic X-Ray and Lab Services	Covered in Full
Physical Therapy	$10 co-pay; (60 consecutive days per condition)
Mental Health and Substance Use Disorders – Outpatient	$10 co-pay
Durable Medical Equipment	Plan pays 80% coverage (up to $5,000 per calendar year)
Ambulance Service	Covered in Full
Allergy Testing and Treatment	$5 co-pay
Maternity Coverage	
In-Hospital (Delivery)	Covered in Full
Out-of-Hospital (prenatal care)	Covered in Full
Other Services	
Skilled Nursing Facilities	Covered in Full (up to 100 days per calendar year)
Home Health Services	Covered in Full (with authorization)
Hospice Care	Covered in Full
Cardiac Rehabilitation	$10 co-pay
Chiropractic Services	$10 co-pay (up to 12 visits per year)
Podiatrist Services (limited services only)	$10 co-pay per visit

CVS caremark® PRESCRIPTION DRUG COVERAGE (CVS/caremark or participating pharmacies)

Maintenance drugs are required to be a 90-day refill and are available via mail order or can be picked up at a CVS Pharmacy.

Up to a 30-Day Supply	90-Day Maintenance Drug Supply
$10 co-pay – Generic Drugs $30 co-pay – Preferred Brand-Name $50 co-pay – Non-Preferred Brand-Name	$20 co-pay – Generic Drugs $60 co-pay – Preferred Brand-Name $100 co-pay – Non-Preferred Brand-Name

MEDICAL COVERAGE TERMS TO UNDERSTAND

Coinsurance: The plan's share of the charges that are paid after you have met any deductibles. If a plan pays 80%, for example, you would pay the remaining 20%, up to the plan's annual out-of-pocket maximum.

Co-pay: The amount you pay per service received, such as office visits, emergency care, prescription drugs, etc.

Deductible: The amount you pay before a plan pays any benefits. Neither post-tax medical plan has a deductible.

Primary Care Physician (PCP): The doctor you select to provide your medical care and help you find a specialist. Each covered family member may select his or her own PCP.

Out-of-Pocket Maximum: The most you would have to pay in deductibles and coinsurance in a calendar year before the plan pays 100% of covered services.

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