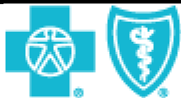
SAINT MICHAEL'S COLLEGE
BENEFIT PLAN COMPARISON

SERVICE or BENEFIT DESCRIPTION	VERMONT FREEDOM PLAN PPO		VERMONT HEALTH PARTNERSHIP EXCLUSIVE PROVIDER PLAN
Note: This is only a general description of benefits. Please see a Certificate of Coverage for full details about your coverage.	In Network	Out of Network	
DEDUCTIBLE	N/A	$300 Individual $900 Family	N/A
COINSURANCE	N/A	30% (your portion)	N/A
ANNUAL OUT-OF-POCKET MAXIMUM (Not including per-visit co-payments)	N/A	$3,000 Individual $9,000 Family	N/A
LIFETIME MAXIMUM BENEFIT	Unlimited	Unlimited	Unlimited
DOCTOR'S OFFICE SERVICES All visits to primary care physicians and specialists Well-child care, physical examinations Routine immunizations Allergy tests and treatment Pre-natal / post-natal maternity care Speech, physical and occupational therapy to 30 visits combined per calendar year	$10 per-visit co-payment	Subject to deductibles above and 30% coinsurance	$15 per-visit co-payment One co-payment covers all pre- and post-natal care plus the fee for delivery
MENTAL HEALTH CARE Outpatient	$10 per-visit co-payment Must use MBC mental health providers and call for prior approval at 1-800-395-1356	Subject to deductibles above and 50% coinsurance (even after you meet your out-of-pocket maximum) Coinsurance does not apply to OOP max	$15 per-visit co-payment Must use MBC network mental health providers and call for prior approval at 1-800-395-1356
Inpatient	$100 co-payment then covered in full Must use MBC mental health providers and call for prior approval at 1-800-395-1356	Preadmission review required for inpatient service only. Call MBC at 1-800-395-1356	$150 co-payment, then covered in full Must use MBC network mental health providers and call for prior approval at 1-800-395-1356
SUBSTANCE ABUSE CARE Outpatient	$10 per-visit co-payment Must use MBC substance abuse treatment providers and call for prior approval at 1-800-395-1356	Subject to deductibles above and 50% coinsurance (even after you meet your out-of-pocket maximum) Coinsurance does not apply to OOP max	$15 per-visit co-payment Must use MBC network substance abuse treatment providers and call for prior approval at 1-800-395-1356
Inpatient	$100 co-payment then covered in full Must use MBC network substance abuse providers and call for prior approval at 1-800-395-1356	Provider must participate with BCBSVT Preadmission review required for in patient services only. Call MBC at 1-800-395-1356	$150 co-payment, then covered in full Must use MBC network substance abuse providers and call for prior approval at 1-800-395-1356



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SERVICE or BENEFIT DESCRIPTION	VERMONT FREEDOM PLAN PPO		VERMONT HEALTH PARTNERSHIP EXCLUSIVE PROVIDER PLAN
	In Network	Out of Network	
INPATIENT CARE Room and board in a general hospital All surgeons' and physicians' services including operations, anesthesia, consultations, laboratory, X-Ray services, medications, radiation, physical, inhalation and other therapies	$100 co-payment then covered in full Pre admission review required	Subject to deductibles above and 30% co-insurance Pre admission review required	$150 co-payment, then covered in full Pre admission review required
HOSPITAL OUTPATIENT Surgery	$50 co-payment then covered full	Subject to deductibles above and 30% co-insurance	$75 co-payment, then covered in full
All other services approved and prescribed by a physician, including radiation therapy and hemodialysis outpatient procedures	Covered in full	Subject to deductibles above and 30% co-insurance	Covered in full
EMERGENCY ROOM Care for life- or health-threatening conditions in or out of the service area	$50 co-payment per visit (waived if you're admitted)	Subject to deductibles above and 30% co-insurance	$50 co-payment per visit (waived if you're admitted)
AMBULANCE SERVICE (In or Out-of-Area) Ambulance service when medically necessary	Covered in full	Covered in full	$50 co-payment
HOME CARE / HOME HEALTH AGENCIES Home care by a home health agency Hospice care	Covered in full	No benefit	Covered in full
Private duty nursing to $2,000 per person per year	Covered in full	Subject to deductibles above and 30% co-insurance	$15 co-payment
PHYSICAL REHABILITATION			
Outpatient cardiac rehabilitation	Covered in full	No benefit	Covered in full
Physical rehabilitation facility	$100 co-payment then covered in full	No benefit	$150 co-payment then covered in full
OUTPATIENT PRESCRIPTIONS	$5 per generic prescription $15 per preferred brand-name prescription $30 per non-preferred brand prescription Unlimited maximum	No benefit	$5 per generic prescription $20 per preferred brand-name prescription $35 per non-preferred brand prescription Unlimited maximum
DURABLE MEDICAL EQUIPMENT, PROSTHETICS	Covered in full	Subject to deductibles above and 30% co-insurance	Covered in full $3,000 annual limit
CHIROPRACTIC	$10 visit fee Prior approval required after 12th visit	No benefit	$15 visit fee Prior approval required after 12th visit
ANNUAL VISION EXAMINATION **Through Vision Service Plan** **1-800-877-7195 www.vsp.com**	$20 co-payment with Vision Service Plan Provider	No benefit	$20 co-payment with Vision Service Plan Provider