Vermont
Plan Name: MVP VT Plus Bronze 5
Plan Form: FRVT-HMO-B-005-N (2026)
Plan Status: Active

	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	$9,950 Person/$19,900 Family - Embedded	None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	$9,950 Person/$19,900 Family - Embedded	None
Primary Care Physician Office Visits	0% coinsurance*	First 3 PCP or MH/SA Visits Covered in Full
Specialist Office Visits	0% coinsurance*	None
Preventive & Well Care Services		
Well Child Care & Immunizations Adult Annual Physical (One per Contract Year) Mammography Annual Pap Test & Ob/Gyn Exam Immunizations for Adults Colonoscopy /Sigmoidoscopy Screening Bone Density Tests	Covered in Full. For a full list of covered preventive care services, visit **mvphealthcare.com**.	None
Physician Office Visits		
Diagnostic Laboratory Services	PCP: 0% coinsurance*/Spec: 0% coinsurance*	None
Diagnostic X-ray	PCP: 0% coinsurance*/Spec: 0% coinsurance*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 0% coinsurance*/Free-Stnd: 0% coinsurance*	Prior authorization is required for some services
Rehabilitative Services (PT/OT/ST)	0% coinsurance*	30 combined PT/OT/ST visits per year. Speech/Occupational Therapy follows Specialist cost share
Allergy Services	0% coinsurance*	None
Chemotherapy Visit	0% coinsurance*	0% coinsurance*
Inpatient Services - Hospital		
Medical/Surgical Admissions	0% coinsurance*	Prior authorization is required for some services
Surgical Services	0% coinsurance*	Prior authorization is required for some services
Inpatient Physical Rehabilitation	0% coinsurance*	None
Outpatient Hospital Services		
Hospital Rehab Services (OT/ST)	0% coinsurance*	30 combined PT/OT/ST visits per year
Hospital Rehab Services (PT)	$45 copay*	30 combined PT/OT/ST visits per year
Diagnostic Laboratory Services	PCP: 0% coinsurance*/Spec: 0% coinsurance*	None
Diagnostic X-ray	0% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)	0% coinsurance*	Prior authorization is required for some services
Ambulatory/Outpatient Surgery	0% coinsurance*	Prior authorization is required for some services
Emergency Care		
Emergency Room (ER) Visit	0% coinsurance*	None
Urgent Care Centers	0% coinsurance*	None
Ambulance (Emergency Medical Transportation)	0% coinsurance*	None
Maternity Services		
Maternity – Prenatal Care	0% coinsurance*	None
Maternity – Physician Delivery	0% coinsurance*	None
Maternity – Inpatient Hospital Services	0% coinsurance*	None

*Deductible applies to this benefit

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	Coverage Information	Limits and Exclusions
Behavioral Health Services		
Mental Health Inpatient Hospital	0% coinsurance*	None
Mental Health Outpatient	0% coinsurance*	First 3 PCP or MH/SA Visits Covered in Full
Substance Use Disorder Inpatient Hospital	0% coinsurance*	None
Substance Use Disorder Outpatient	0% coinsurance*	First 3 PCP or MH/SA Visits Covered in Full
Residential Treatment	50% coinsurance*	None
Other Services		
Physician Administered Drugs	0% coinsurance*	None
Skilled Nursing Facility	0% coinsurance*	None
Home Health Care	0% coinsurance*	None
Hospice	0% coinsurance*	None
Durable Medical Equipment	0% coinsurance*	Prior authorization is required for some items
Diabetic Supplies & Equipment	0% coinsurance*	Prior authorization is required for some items
Chiropractic Benefit	0% coinsurance*	No visit limit for Chiropractic Care
Acupuncture	$500 allowance	None
Prescription Drug Coverage		
Tier 1	30 day supply: $10 copay/90 day supply: $25 copay	VBID 30 day supply $1/90 day supply $2.50. $0 generics to age 10
Tier 2	0% coinsurance*	VBID 30 day supply $1/90 day supply $2.50. Prior authorization is required for some prescriptions
Tier 3	0% coinsurance*	VBID 30 day supply $1/90 day supply $2.50. Prior authorization is required for some prescriptions. Includes Diabetic Supplies and Equipment
Prescription Drug Deductible	Subject to annual deductible	None
Prescription Out-of-Pocket Maximum	Integrated with medical	None
Vision Care		
Adult Vision Care	Not covered	None
Pediatric Vision Care	$20 copay	One eye exam per year to age 21
Other Plan Features		
Gia® Virtual Care	Covered in Full	None
Wellness Benefits	$600 allowance	None
	Specialty virtual care providers included in Gia may be subject to the plan's applicable cost-share.	

This plan overview is intended to provide a general outline of coverage. In the event of any conflict between this document and your Certificate of Coverage (COC), Schedule, and any applicable Rider(s), your COC, Schedule, and Rider(s) will be controlling. For plan details, please call 1-800-TALK-MVP (825-5687), or visit mvphealthcare.com.

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*Deductible applies to this benefit