Vermont
Plan Name: MVP VT Bronze 2
Plan Form: FRVT-HMO-SB-002-S (2026)
Plan Status: Active

Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	$6,450 Person/$12,900 Family - Embedded	None
Co-insurance	50% Person/50% Family	None
Annual Out-of-Pocket Maximum	$10,150 Person/$20,300 Family - Embedded	None
Primary Care Physician Office Visits	$35 copay*	None
Specialist Office Visits	$90 copay*	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: $35 copay*/Spec: $90 copay*	None
Diagnostic X-ray	PCP: $35 copay*/Spec: $90 copay*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 50% coinsurance*/Free-Stnd: 50% coinsurance*	Prior authorization is required for some services
Rehabilitative Services (PT/OT/ST)	$45 copay*	30 combined PT/OT/ST visits per year. Speech/Occupational Therapy follows Specialist cost share
Allergy Services	$90 copay*	None
Chemotherapy Visit	$90 copay*	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	50% coinsurance*	Prior authorization is required for some services
Surgical Services	50% coinsurance*	Prior authorization is required for some services
Inpatient Physical Rehabilitation	50% coinsurance*	None
Outpatient Hospital Services		
Hospital Rehab Services (OT/ST)	$90 copay*	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	50% coinsurance*	None
Diagnostic X-ray	50% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)	50% coinsurance*	Prior authorization is required for some services
Ambulatory/Outpatient Surgery	50% coinsurance*	Prior authorization is required for some services
Emergency Care		
Emergency Room (ER) Visit	50% coinsurance*	None
Urgent Care Centers	$100 copay*	None
Ambulance (Emergency Medical Transportation)	$100 copay*	None
Maternity Services		
Maternity – Prenatal Care	$35 copay*	None
Maternity – Physician Delivery	50% coinsurance*	None
Maternity – Inpatient Hospital Services	50% coinsurance*	None

***Deductible applies to this benefit**

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	Coverage Information	Limits and Exclusions
Behavioral Health Services		
Mental Health Inpatient Hospital	50% coinsurance*	None
Mental Health Outpatient	$35 copay*	None
Substance Use Disorder Inpatient Hospital	50% coinsurance*	None
Substance Use Disorder Outpatient	$35 copay*	None
Residential Treatment	50% coinsurance*	None
Other Services		
Physician Administered Drugs	50% coinsurance*	None
Skilled Nursing Facility	50% coinsurance*	None
Home Health Care	50% coinsurance*	None
Hospice	50% coinsurance*	None
Durable Medical Equipment	50% coinsurance*	Prior authorization is required for some items
Diabetic Supplies & Equipment	60% coinsurance	Prior authorization is required for some items
Chiropractic Benefit	$45 copay*	No visit limit for Chiropractic Care.
Acupuncture	Not covered	None
Prescription Drug Coverage		
Tier 1	30 day supply: $15 copay/90 day supply: $37.50 copay	None
Tier 2	30 day supply: $85 copay*/90 day supply: $212.50 copay*	Prior authorization is required for some prescriptions
Tier 3	60% coinsurance*	Prior authorization is required for some prescriptions. Includes Diabetic Supplies and Equipment
Prescription Drug Deductible	Rx Brand - $1,100 individual / $2,200 family	None
Prescription Out-of-Pocket Maximum	$1,650 Person/$3,300 Family - Embedded	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	Not covered	None
Plan Highlights	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**