**Vermont**
**Plan Name:** MVP VT Reflective Silver 3
**Plan Form:** VT-HMO-SS-003-S II (2026)
**Plan Status:** Active

| Plan Cost-Sharing Highlights | Coverage Information | Limits and Exclusions |
|---|---|---|
| Annual Deductible per Contract Year | $3,500 Person/$7,000 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 | $40 copay | First 3 PCP or MH/SA Visits Covered in Full |
| Specialist Office Visits | $90 copay | None |
| **Preventive & Well Care Services** | | |
| Well Child Care & Immunizations<br>Adult Annual Physical (One per Contract Year)<br>Mammography<br>Annual Pap Test & Ob/Gyn Exam<br>Immunizations for Adults<br>Colonoscopy /Sigmoidoscopy Screening<br>Bone Density Tests | Covered in Full.<br>For a full list of covered preventive care services, visit mvphealthcare.com. | None |
| **Physician Office Visits** | | |
| Diagnostic Laboratory Services | PCP: $40 copay/Spec: $90 copay | None |
| Diagnostic X-ray | PCP: $40 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) | $50 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) | $50 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 | $250 copay* | None |
| Urgent Care Centers | $100 copay | None |
| Ambulance (Emergency Medical Transportation) | $105 copay | None |
| **Maternity Services** | | |
| Maternity – Prenatal Care | $40 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 | $40 copay | First 3 PCP or MH/SA Visits Covered in Full |
| Substance Use Disorder Inpatient Hospital | 50% coinsurance* | None |
| Substance Use Disorder Outpatient | $40 copay | First 3 PCP or MH/SA Visits Covered in Full |
| 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 | 50% coinsurance | Prior authorization is required for some items |
| Chiropractic Benefit | $50 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: $70 copay*/90 day supply: $175 copay* | Prior authorization is required for some prescriptions |
| Tier 3 | 50% coinsurance* | Prior authorization is required for some prescriptions. Includes Diabetic Supplies and Equipment |
| Prescription Drug Deductible | Rx Brand - $500 individual / $1,000 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**.

Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and counties.

***Deductible applies to this benefit**