**Vermont**
**Plan Name:** MVP VT Bronze 2
**Plan Form:** FRVT-HMO-B-002-S
**Plan Status:** Active

| | Coverage Information | Limits and Exclusions |
|---|---|---|
| **Plan Cost-Sharing Highlights** | | |
| Annual Deductible per Contract Year | $6,450 Person/$12,900 Family - Embedded | None |
| Co-insurance | 50% coinsurance* | None |
| Annual Out-of-Pocket Maximum | $11,100 Person/$22,200 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 | Covered in Full not subject to Deductible For a full list of covered preventive care services, visit mvphealthcare.com. | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| Adult Annual Physical (One per Contract Year) | | |
| Mammography | | |
| Annual Pap Test & Ob/Gyn Exam | | |
| Immunizations for Adults | | |
| Colonoscopy /Sigmoidoscopy Screening | | |
| Bone Density Tests | | |
| **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 Rehabilitation Services (PT/OT/ST) | $90 copay* | 30 combined PT/OT/ST visits per year. OP PT applies Other practitioner office visit cost share in all OP settings |
| 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 |
| Infusion Therapy | 50% coinsurance* | None |
| **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 Office Visit | $35 copay* | None |
| Maternity – Physician Delivery | 50% coinsurance* | None |
| Maternity – Inpatient Hospital Services | 50% coinsurance* | None |
| **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 |

*Deductible applies to this benefit

**Vermont**
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|---|---|---|
| Autism Treatment | $90 copay* | None |
| Assistive Communication Devices for Autism Spectrum Disorder | 50% coinsurance* | None |
| **Other Services** | | |
| Physician Administered Drugs Outpatient | 50% coinsurance* | None |
| Skilled Nursing Facility | 50% coinsurance* | None |
| Home Health Care | 50% coinsurance* | None |
| Hospice | Inpt: 50% coinsurance*/Outpt: 50% coinsurance* | None |
| Durable Medical Equipment | 50% coinsurance* | None |
| Diabetic Supplies & Equipment | 60% coinsurance not subject to Deductible | Prior authorization is required for some items |
| Chiropractic Benefit | $45 copay* | No visit limit for Chiropractic Care. Applies to all outpatient settings |
| Acupuncture | Not covered | None |
| Home Infusion | 50% coinsurance* | None |
| **Prescription Drug Coverage** | | |
| Annual Pharmacy Deductible per Contract Year | $1,100 Person/$2,200 Family | None |
| Annual Pharmacy Out-of-Pocket Maximum | $1,750 Person/$3,500 Family | None |
| Tier 1 | 30 day supply: $15 copay not subject to Deductible /90 day supply: $37.50 copay not subject to Deductible | None |
| Tier 2 | 30 day supply: $85 copay* /90 day supply: $212.50 copay* | Prior authorization is required for some prescriptions |
| Tier 3 | 30 day supply: 60% coinsurance* /90 day supply: 60% coinsurance* | Prior authorization is required for some prescriptions. Includes Diabetic Supplies and Equipment |
| **Ancillary Care** | | |
| Adult Vision Care | Not covered | None |
| Pediatric Vision Care | $20 copay not subject to Deductible | One eye exam per year to age 21 |
| Pediatric Dental | Covered in Full not subject to Deductible | Two dental exams per year to age 21. Adult Dental not covered |
| **Other Plan Features** | | |
| Gia® Virtual Care | Covered in Full not subject to Deductible | None |
| Wellness Benefits | Not covered | None |
| Doula Program | Get reimbursed up to $1,500 per plan year for doula expenses with MVP's Doula Reimbursement Program. | |
| Plan Highlights | Visit **mvphealthcare.com** for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits. | |

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 are available in all states and counties.

***Deductible applies to this benefit**