Vermont
Plan Name: MVP VT Bronze 4
Plan Form: FRVT-HMO-B-004-S
Plan Status: Active

	Coverage Information	Limits and Exclusions
Plan Cost-Sharing Highlights		
Annual Deductible per Contract Year	$12,000 Person/$24,000 Family - Embedded	None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	$12,000 Person/$24,000 Family - Embedded	None
Primary Care Physician Office Visits	$40 copay not subject to Deductible	First 3 PCP or MH/SA Visits Covered in Full
Specialist Office Visits	$100 copay not subject to Deductible	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: $40 copay not subject to Deductible/Spec: $100 copay not subject to Deductible	None
Diagnostic X-ray	PCP: $40 copay not subject to Deductible/Spec: $100 copay not subject to Deductible	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: Covered in Full*/Free-Stnd: Covered in Full*	Prior authorization is required for some services
Rehabilitative Services (PT/OT/ST)	$50 copay not subject to Deductible	30 combined PT/OT/ST visits per year. Speech/Occupational Therapy follows Specialist cost share
Allergy Services	$100 copay not subject to Deductible	None
Chemotherapy Visit	$100 copay not subject to Deductible	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	Covered in Full*	Prior authorization is required for some services
Surgical Services	Covered in Full*	Prior authorization is required for some services
Inpatient Physical Rehabilitation	Covered in Full*	None
Outpatient Hospital Services		
Hospital Rehabilitation Services (PT/OT/ST)	$100 copay not subject to Deductible	30 combined PT/OT/ST visits per year. OP PT applies Other practitioner office visit cost share in all OP settings
Diagnostic Laboratory Services ++	Covered in Full*	None
Diagnostic X-ray ++	Covered in Full*	None
Advanced Imaging Services (CT/PET, scans, MRIs) ++	Covered in Full*	Prior authorization is required for some services
Ambulatory/Outpatient Surgery ++	Covered in Full*	Prior authorization is required for some services
Infusion Therapy	Covered in Full*	None
Emergency Care		
Emergency Room (ER) Visit	Covered in Full*	None
Urgent Care Centers	Covered in Full*	None
Ambulance (Emergency Medical Transportation)	Covered in Full*	None
Maternity Services		
Maternity – Prenatal Care Office Visit	$40 copay not subject to Deductible	None
Maternity – Physician Delivery	Covered in Full*	None
Maternity – Inpatient Hospital Services	Covered in Full*	None
Behavioral Health Services		

*Deductible applies to this benefit

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	Coverage Information	Limits and Exclusions
Mental Health Inpatient Hospital	Covered in Full*	None
Mental Health Outpatient	$40 copay not subject to Deductible	First 3 PCP or MH/SA Visits Covered in Full
Substance Use Disorder Inpatient Hospital	Covered in Full*	None
Substance Use Disorder Outpatient	$40 copay not subject to Deductible	First 3 PCP or MH/SA Visits Covered in Full.
Autism Treatment	$100 copay not subject to Deductible	First 3 PCP or MH/SA Visits Covered in Full
Assistive Communication Devices for Autism Spectrum Disorder	Covered in Full*	None
Other Services		
Physician Administered Drugs Outpatient	Covered in Full*	None
Skilled Nursing Facility	Covered in Full*	None
Home Health Care	Covered in Full*	None
Hospice	Inpt: Covered in Full*/Outpt: Covered in Full*	None
Durable Medical Equipment	Covered in Full*	None
Diabetic Supplies & Equipment	Covered in Full*	Prior authorization is required for some items
Chiropractic Benefit	$50 copay not subject to Deductible	No visit limit for Chiropractic Care. Applies to all outpatient settings
Acupuncture	Not covered	None
Home Infusion	Covered in Full*	None
Prescription Drug Coverage		
Tier 1	30 day supply: $25 copay not subject to Deductible /90 day supply: $62.50 copay not subject to Deductible	None
Tier 2	30 day supply: Covered in Full* /90 day supply: Covered in Full*	Prior authorization is required for some prescriptions
Tier 3	30 day supply: Covered in Full* /90 day supply: Covered in Full*	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**