Vermont
Plan Name: MVP VT Plus Bronze 1
Plan Form: FRVT-HMO-B-001-N (2025)
Plan Status: Active

Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	$7,250 Person/$14,500 Family - Embedded	None
Co-insurance	50% Person/50% Family	None
Annual Out-of-Pocket Maximum	$8,400 Person/$16,800 Family - Embedded	None
Primary Care Physician Office Visits	$40 copay*	First 3 PCP or MH/SA Visits Covered in Full
Specialist Office Visits	$100 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: $40 copay*/Spec: $100 copay*	None
Diagnostic X-ray	PCP: $40 copay*/Spec: $100 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	$100 copay*	None
Chemotherapy Visit	$100 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)	50% coinsurance*	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	50% coinsurance*	None
Urgent Care Centers	$100 copay*	None
Ambulance (Emergency Medical Transportation)	$100 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	$80 copay*	Prior authorization is required for some items
Chiropractic Benefit	$50 copay*	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	30 day supply: $50 copay*/90 day supply: $125 copay*	VBID 30 day supply $1/90 day supply $2.50. Prior authorization is required for some prescriptions
Tier 3	30 day supply: $80 copay*/90 day supply: $200 copay*	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	Rx Brand - $700 individual / $1,400 family	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	Get reimbursed up to $600 per contract, per calendar year
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**.

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Deductible applies to this benefit