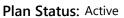
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Plan Name: MVP VT Plus Bronze 5
Plan Form: FRVT-HMO-B-005-N (2025)





Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$9,200 Person/\$18,400 Family - Embedded	None
Co-insurance	As Noted Below	None
	\$9,200 Person/\$18,400 Family - Embedded	None
Annual Out-of-Pocket Maximum		
Primary Care Physician Office Visits	0% coinsurance*	First 3 PCP or MH/SA Visits Covered in Full
Specialist Office Visits	0% coinsurance*	None
Preventive & Well Care Services		
Well Child Care & Immunizations		
Adult Annual Physical (One per Contract Year)	Covered in Full.	
Mammography	For a full list of covered preventive care	
Annual Pap Test & Ob/Gyn Exam	services, visit	None
Immunizations for Adults	mvphealthcare.com.	
Colonoscopy /Sigmoidoscopy Screening		
Bone Density Tests		
Physician Office Visits	PCP: 0% coinsurance*/Spec: 0% coinsurance*	None
Diagnostic Laboratory Services	Ter. 0% comsurance / Spec. 0% comsurance	None
	PCP: 0% coinsurance*/Spec: 0% coinsurance*	None
Diagnostic X-ray	FCF. 0% comsulance /Spec. 0% comsulance	None
	Spec: 0% coinsurance*/Free-Stnd: 0%	Prior authorization is required for some services
Advanced Imaging Services (CT/PET scans, MRIs)	·	riioi autiioiizatioii is required ioi soilie services
	coinsurance* 0% coinsurance*	30 combined PT/OT/ST visits per year.
	070 combutance	
Rehabilitative Services (PT/OT/ST)		Speech/Occupational Therapy follows Specialist
(,, , ,, ,,		cost share
Allergy Services	0% coinsurance*	None
Chemotherapy Visit	0% coinsurance*	None
Inpatient Services - Hospital		
inpatient Services - Hospital	0% coinsurance*	Prior authorization is required for some services
Medical/Surgical Admissions	070 comsurance	Thor authorization is required for some services
Surgical Services	0% coinsurance*	Prior authorization is required for some services
Inpatient Physical Rehabilitation	0% coinsurance*	None
Outpatient Hospital Services		
Hospital Rehab Services (OT/ST)	0% coinsurance*	30 combined PT/OT/ST visits per year
Hospital Rehab Services (PT)	0% coinsurance*	30 combined PT/OT/ST visits per year
Diagnostic Laboratory Services	0% coinsurance*	None
Diagnostic X-ray	0% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)	0% coinsurance*	Prior authorization is required for some services
Ambulatory/Outpatient Surgery	0% coinsurance*	Prior authorization is required for some services
Emergency Care		
Emergency Room (ER) Visit	0% coinsurance*	None
Urgent Care Centers	0% coinsurance*	None
Ambulance (Emergency Medical Transportation)	0% coinsurance*	None
Maternity Services		
Maternity – Prenatal Care	0% coinsurance*	None
Maternity – Physician Delivery	0% coinsurance*	None
materinty - rhysician Denvery	0% coinsurance*	
Maternity – Inpatient Hospital Services	0% comsurance"	None

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Plan Name: MVP VT Plus Bronze 5
Plan Form: FRVT-HMO-B-005-N (2025)

Plan Status: Active



	Coverage Information	Limits and Exclusions	
Behavioral Health Services			
Mental Health Inpatient Hospital	0% coinsurance*	None	
Mental Health Outpatient	0% coinsurance*	First 3 PCP or MH/SA Visits Covered in Full	
Substance Use Disorder Inpatient Hospital	0% coinsurance*	None	
Substance Use Disorder Outpatient	0% coinsurance*	First 3 PCP or MH/SA Visits Covered in Full	
Residential Treatment	0% coinsurance*	None	
Other Services			
Physician Administered Drugs	0% coinsurance*	None	
Skilled Nursing Facility	0% coinsurance*	None	
Home Health Care	0% coinsurance*	None	
Hospice	0% coinsurance*	None	
Durable Medical Equipment	0% coinsurance*	Prior authorization is required for some items	
Diabetic Supplies & Equipment	0% coinsurance*	Prior authorization is required for some items	
Chiropractic Benefit	0% coinsurance*	No visit limit for Chiropractic Care	
Acupuncture	\$500 allowance	None	
Prescription Drug Coverage			
	30 day supply: \$10 copay/90 day supply:	VBID 30 day supply \$1/90 day supply \$2.50. \$0 generics to	
Tier 1	\$25 copay	age 10	
Tier 2	0% coinsurance*	VBID 30 day supply \$1/90 day supply \$2.50. Prior authorization is required for some prescriptions	
	30 day supply: \$0 copay*/90 day supply: 0% coinsurance*	VBID 30 day supply \$1/90 day supply \$2.50. Prior authorization is required for some prescriptions. Includes	
Tier 3	consulance	Diabetic Supplies and Equipment	
Prescription Drug Deductible	Subject to annual deductible	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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