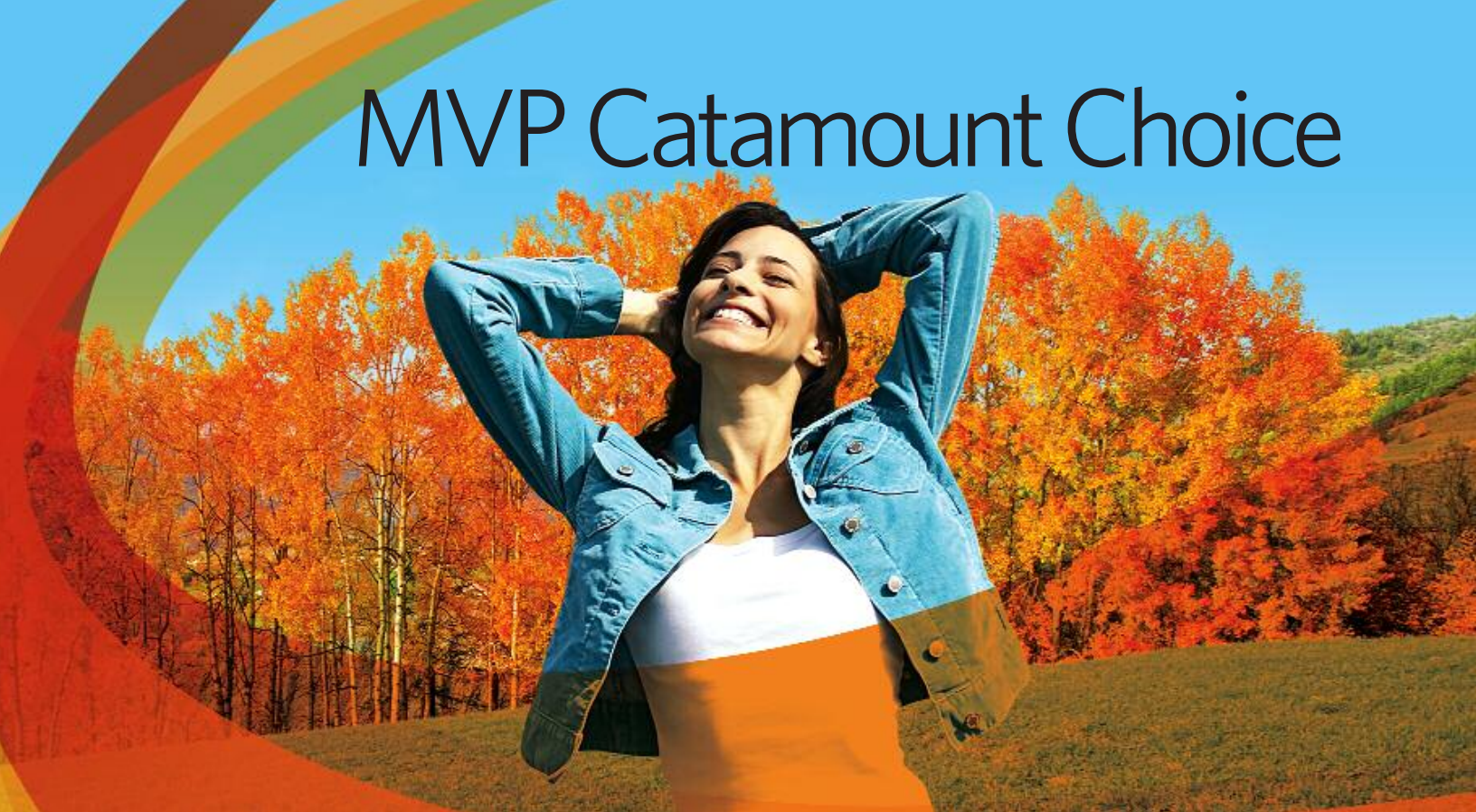


# MVP Catamount Choice



## A health plan just for Vermonters from MVP Health Care



### MVP Catamount Choice offers you the coverage you need:

- Primary care/hospital visits
- Prescription drug coverage
- Free wellness visits
- Preventive dental for kids and adolescents
- Urgent care

### Services that help you take on life and live well:

- Care management programs to help you manage common diseases
- Time saving and innovative Web services
- MVP's PersonalAdvocate - a Registered Nurse that you can call to discuss health questions and concerns 24/7

### Everything you need in a health plan and more!

#### **PLEASE NOTE Pre-existing Condition Limitation for members age 19 and over:**

Coverage under the Catamount Health program is subject to a pre-existing condition waiting period. This means if you have been diagnosed with, treated for or advised to seek treatment by a healthcare professional for a medical condition in the last twelve (12) months, services for the treatment of that condition may be excluded from coverage for up to a year.

#### **However**

- **If members have had prior health insurance coverage and have not had a break in coverage that is longer than 63 days, the pre-existing condition limitation waiting period will be reduced or waived**
- **Coverage for other services will still be available for all other covered conditions.**

#### **MVP Health Care's Chronic Care Program has the following programs:**

- Asthma Care Program
- Diabetes Care Program
- Back Care Program
- Depression Care Program
- COPD Care Program
- Cardiac Care Program (Participation in the disease management Cardiac Program is only available following an acute hospitalization for a heart attack, cardiac bypass surgery or angioplasty)

If you are eligible and choose to participate in any of these programs you may receive reduced cost-sharing, including the waiver of copayments and waiting periods for chronic care services. Please contact MVP if you are interested in participating.



# MVP Catamount Choice

## Summary of Benefits

**Vermont**  
 1-888-MVP-MBRS (1-888-687-6277)  
 joinmvp.com

### July 1, 2011 - June 30, 2012 Monthly Premium Rates:

**Single** - \$512.60; **Double** - \$1,025.20; **Parent with Child(ren)** - \$978.45; **Family** - \$1,444.31

*These rates do not include state premium assistance, if applicable.*

		INDIVIDUAL	FAMILY
<b>In-Network Contract Year Deductible<sup>1</sup></b>		\$500	\$1,000 <sup>2</sup>
<b>Out-of-Network Contract Year Deductible<sup>1</sup></b>		\$1,000	\$2,000 <sup>2</sup>
<b>In Network Annual Out-of-Pocket Maximum<sup>3</sup></b>		\$1,050	\$2,100 <sup>2</sup>
<b>Out-of-Network Annual Out-of-Pocket Maximum<sup>3</sup></b>		\$2,100	\$4,000 <sup>2</sup>
<b>General Lifetime Maximum Benefit</b>	No Maximum		
<b>Durable Medical Equipment/External Prosthetic Devices/ Ostomy Supplies Lifetime Maximum Benefit</b>	No Maximum		
<b>Medical Foods Maximum Benefit per Member per year</b>	No Maximum		

BENEFIT	IN-NETWORK COINSURANCE	OUT-OF-NETWORK COINSURANCE
<b>Inpatient Hospital Services</b>		
Maternity Care		20%
Newborn Care		20%
Breast Cancer Care		20%
Physical Rehabilitation Care		Not Available
Mental Health and Substance Abuse Services	20%	20%
<b>Outpatient Hospital/Facility and Ambulatory Services<sup>4</sup></b>		
Mental Health and Substance Abuse Services (Facility)		
Therapeutic Services		
Pre-admission Testing		
Diagnostic Tests and Screenings	20%	20%
Diagnostic Laboratory		
Diagnostic Radiology		
Breast Cancer Care		
Therapy Services (PT/ST/OT)		
Cardiac Rehabilitation		Not Available
<b>Covered Preventive Care Services</b>		
Well Baby and Child Care (Including immunizations)		
Adult periodic physicals		
Adult Immunizations (Must be provided during annual physical. Except for Influenza, Tetanus, Diphtheria, Hepatitis B and Hepatitis A.)	Covered in Full	Not Available
Mammography Screenings		
Prostate Cancer Screening		
Cervical Cytology Screening		

<sup>1</sup>This Deductible does not apply to the following Covered Services: Maternity Care (and maternity-related care, including Diagnostic Services and Laboratory Services), Newborn Care, In-Network Diabetes Equipment and Supplies, Durable Medical Equipment, External Prosthetic Devices, including Breast Prostheses, and Ostomy Supplies. Also, there is no Deductible for covered Services that are subject to Copayment.

<sup>2</sup>The family deductible and out-of-pocket maximum shall be satisfied when either one insured or a combination of insureds satisfies the annual family deductible during contract year.

<sup>3</sup>The following Member payments do not count toward the In-Network or Out-of-Network Annual Out of Pocket Maximum: Prescription Drug Copayments, and Charges in excess of Allowable Charges.

<sup>4</sup>Includes Pre-admission testing, Surgery, Therapeutic Services, Diagnostic Services and Laboratory Services.

BENEFIT	IN-NETWORK COINSURANCE	OUT-OF-NETWORK COINSURANCE
<b>Covered Professional Services &amp; Supplies</b>		
Provider Office Visits <sup>5</sup>		
Therapeutic Services Office Setting		\$10 Copayment
Maternity Care <sup>6</sup>		
Child Birth Classes		You will be reimbursed up to \$40
Parenting Classes		You will be reimbursed up to \$25
Consultations (Inpatient setting)		20%
Mental Health & Substance Abuse Services (Office)		\$10 Copayment
Chiropractic Care (Office setting)	\$10 Copayment	Not Available
Inpatient Medical Care		20%
Surgery		
Facility Setting		20%
Office Setting		\$10 Copayment
Second Surgical Opinions (Office setting)		\$10 Copayment
Assistant Surgeon (Inpatient setting)		20%
Anesthesia Services (Inpatient setting)		20%
Office Therapy Services (PT/ST/OT)	\$10 Copayment	Not Available
Office Laboratory Services <sup>7</sup>	0%	20%
Diagnostic Radiology Services <sup>7</sup>	\$10 Copayment	
Transplant Services/Donor Costs		Not Available
Medical Foods		
Diabetes Equipment & Supplies <sup>8</sup>	20%	
Durable Medical Equipment, External Prosthetic Devices, Ostomy Supplies and Breast Prostheses		20%
<b>Other Benefits</b>		
Skilled Nursing Facility Services		
Home Health Agency Services	20%	Not Available
Hospice Services		
Emergency Services		20% <sup>9</sup>
Ambulance Services		
Urgently-Needed Care		20%
Basic Infertility Services		
Facility Setting		
Office Setting		\$10 Copayment
Abortion/Sterilization		20%
Preventive Dental for Kids		\$25 Copayment
Prescription Drug Coverage	\$10 Generic Formulary \$35 Brand Formulary \$55 Non-Formulary	\$10 Generic Formulary \$35 Brand Formulary \$55 Non-Formulary

<sup>5</sup>Includes office visits for: diagnosis and treatment, Second Surgical Opinions, Diabetes Treatment, Breast Cancer Care, and Diagnostic Services.

<sup>6</sup>Copayment applies to first diagnostic visit only (no Copayments apply thereafter).

<sup>7</sup>Processing/professional fees that are performed outside of the office setting are subject to Deductible and Coinsurance.

<sup>8</sup>For supplies, applicable per item per 30 day supply.

<sup>9</sup>Subject to In-network contract year deductible.