

**Vermont**  
**Plan Name:** MVP VT Gold 1  
**Plan Form:** FRVT-HMO-G-001-S (2023)  
**Plan Status:** Active



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$1,400 Person/\$2,800 Family - Embedded	None
Co-insurance	30% Person/30% Family	None
Annual Out-of-Pocket Maximum	\$5,600 Person/\$11,200 Family - Embedded	None
Primary Care Physician Office Visits	\$20 copay	First 3 PCP or MH/SA Visits Covered in Full
Specialist Office Visits	\$50 copay	None
<b>Preventive &amp; Well Care Services</b>		
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 <a href="http://mvphealthcare.com">mvphealthcare.com</a> .	None
<b>Physician Office Visits</b>		
Diagnostic Laboratory Services	PCP: \$20 copay/Spec: \$50 copay	None
Diagnostic X-ray	PCP: \$20 copay/Spec: \$50 copay	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 30% coinsurance*/Free-Stnd: 30% coinsurance* \$30 copay	Prior authorization is required for some services
Rehabilitative Services (PT/OT/ST)		30 combined PT/OT/ST visits per year. Speech/Occupational Therapy follows Specialist cost share
Allergy Services	\$50 copay	None
Chemotherapy Visit	\$50 copay	None
<b>Inpatient Services - Hospital</b>		
Medical/Surgical Admissions	30% coinsurance*	Prior authorization is required for some services
Surgical Services	30% coinsurance*	Prior authorization is required for some services
Inpatient Physical Rehabilitation	30% coinsurance*	None
<b>Outpatient Hospital Services</b>		
Hospital Rehab Services (OT/ST)	30% coinsurance*	30 combined PT/OT/ST visits per year.
Hospital Rehab Services (PT)	\$30 copay	30 combined PT/OT/ST visits per year.
Diagnostic Laboratory Services	30% coinsurance*	None
Diagnostic X-ray	30% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)	30% coinsurance*	Prior authorization is required for some services
Ambulatory/Outpatient Surgery	30% coinsurance*	Prior authorization is required for some services
<b>Emergency Care</b>		
Emergency Room (ER) Visit	\$150 copay*	None
Urgent Care Centers	\$60 copay	None
Ambulance (Emergency Medical Transportation)	\$70 copay	None
<b>Maternity Services</b>		
Maternity – Prenatal Care	\$20 copay	None
Maternity – Physician Delivery	30% coinsurance*	None
Maternity – Inpatient Hospital Services	30% coinsurance*	None

	Coverage Information	Limits and Exclusions
<b>Behavioral Health Services</b>		
Mental Health Inpatient Hospital	30% coinsurance*	None
Mental Health Outpatient	\$20 copay	First 3 PCP or MH/SA Visits Covered in Full
Substance Use Disorder Inpatient Hospital	30% coinsurance*	None
Substance Use Disorder Outpatient	\$20 copay	First 3 PCP or MH/SA Visits Covered in Full
Residential Treatment	30% coinsurance*	None
<b>Other Services</b>		
Physician Administered Drugs	30% coinsurance*	None
Skilled Nursing Facility	30% coinsurance*	None
Home Health Care	30% coinsurance*	None
Hospice	30% coinsurance*	None
Durable Medical Equipment	30% coinsurance*	Prior authorization is required for some items
Diabetic Supplies & Equipment	50% coinsurance*	Prior authorization is required for some items
Chiropractic Benefit	\$30 copay	No visit limit for Chiropractic Care.
Acupuncture	Not covered	None
<b>Prescription Drug Coverage</b>		
Tier 1	30 day supply: \$12 copay/90 day supply: \$30 copay	None
Tier 2	30 day supply: \$55 copay*/90 day supply: \$137.50 copay*	Prior authorization is required for some prescriptions
Tier 3	50% coinsurance*	Prior authorization is required for some prescriptions. Includes Diabetic Supplies and Equipment
Prescription Drug Deductible	Rx Brand - \$200 individual / \$400 family	None
Prescription Out-of-Pocket Maximum	\$1,400 Person/\$2,800 Family - Embedded	None
<b>Vision Care</b>		
Adult Vision Care	Not covered	None
Pediatric Vision Care	\$20 copay	One eye exam per year to age 21
<b>Other Plan Features</b>		
Gia® Virtual Care	Covered in Full	None
Wellness Benefits	Not covered	None
Visit <a href="https://mvphealthcare.com">mvphealthcare.com</a> for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.		

Gia virtual care services are available at no member cost-share for medical plans, including qualified high-deductible health plans (QHDHPs), upon enrollment and plan renewal in 2023. Members enrolled in a 2022 QHDHP must meet the plan's annual deductible before Gia services are available at no member cost share.

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](https://mvphealthcare.com).

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