

# Vermont

Plan Name: MVP VT Platinum 1

Plan Form: FRVT-HMO-P-001-S (2023)

Plan Status: Active



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$425 Person/\$850 Family - Embedded	None
Co-insurance	10% Person/10% Family	None
Annual Out-of-Pocket Maximum	\$1,500 Person/\$3,000 Family - Embedded	None
Primary Care Physician Office Visits	\$15 copay	First 3 PCP or MH/SA Visits Covered in Full
Specialist Office Visits	\$40 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: \$15 copay/Spec: \$40 copay	None
Diagnostic X-ray	PCP: \$15 copay/Spec: \$40 copay	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 10% coinsurance*/Free-Stnd: 10% coinsurance* \$20 copay	Prior authorization is required for some services 30 combined PT/OT/ST visits per year. Speech/Occupational Therapy follows Specialist cost share
Rehabilitative Services (PT/OT/ST)		
Allergy Services	\$40 copay	None
Chemotherapy Visit	\$40 copay	None
<b>Inpatient Services - Hospital</b>		
Medical/Surgical Admissions	10% coinsurance*	Prior authorization is required for some services
Surgical Services	10% coinsurance*	Prior authorization is required for some services
Inpatient Physical Rehabilitation	10% coinsurance*	None
<b>Outpatient Hospital Services</b>		
Hospital Rehab Services (OT/ST)	10% coinsurance*	30 combined PT/OT/ST visits per year.
Hospital Rehab Services (PT)	\$20 copay	30 combined PT/OT/ST visits per year.
Diagnostic Laboratory Services	10% coinsurance*	None
Diagnostic X-ray	10% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)	10% coinsurance*	Prior authorization is required for some services
Ambulatory/Outpatient Surgery	10% coinsurance*	Prior authorization is required for some services
<b>Emergency Care</b>		
Emergency Room (ER) Visit	\$100 copay*	None
Urgent Care Centers	\$50 copay	None
Ambulance (Emergency Medical Transportation)	\$60 copay	None
<b>Maternity Services</b>		
Maternity – Prenatal Care	\$15 copay	None
Maternity – Physician Delivery	10% coinsurance*	None
Maternity – Inpatient Hospital Services	10% coinsurance*	None

	Coverage Information	Limits and Exclusions
<b>Behavioral Health Services</b>		
<b>Mental Health Inpatient Hospital</b>	10% coinsurance*	None
<b>Mental Health Outpatient</b>	\$15 copay	First 3 PCP or MH/SA Visits Covered in Full
<b>Substance Use Disorder Inpatient Hospital</b>	10% coinsurance*	None
<b>Substance Use Disorder Outpatient</b>	\$15 copay	First 3 PCP or MH/SA Visits Covered in Full
<b>Residential Treatment</b>	10% coinsurance*	None
<b>Other Services</b>		
<b>Physician Administered Drugs</b>	10% coinsurance*	None
<b>Skilled Nursing Facility</b>	10% coinsurance*	None
<b>Home Health Care</b>	10% coinsurance*	None
<b>Hospice</b>	10% coinsurance*	None
<b>Durable Medical Equipment</b>	10% coinsurance*	Prior authorization is required for some items
<b>Diabetic Supplies &amp; Equipment</b>	50% coinsurance	Prior authorization is required for some items
<b>Chiropractic Benefit</b>	\$20 copay	No visit limit for Chiropractic Care.
<b>Acupuncture</b>	Not covered	None
<b>Prescription Drug Coverage</b>		
<b>Tier 1</b>	30 day supply: \$10 copay/90 day supply: \$25 copay	None
<b>Tier 2</b>	30 day supply: \$50 copay/90 day supply: \$125 copay	Prior authorization is required for some prescriptions
<b>Tier 3</b>	50% coinsurance	Prior authorization is required for some prescriptions. Includes Diabetic Supplies and Equipment
<b>Prescription Drug Deductible</b>	None	None
<b>Prescription Out-of-Pocket Maximum</b>	\$1,400 Person/\$2,800 Family - Embedded	None
<b>Vision Care</b>		
<b>Adult Vision Care</b>	Not covered	None
<b>Pediatric Vision Care</b>	\$20 copay	One eye exam per year to age 21
<b>Other Plan Features</b>		
<b>Gia® Virtual Care</b>	Covered in Full	None
<b>Wellness Benefits</b>	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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