Vermont
Plan Name: MVP VT Plus Silver 1 87
Plan Form: FRVT-HMO-S1-002-N (2023)
Plan Status: Active

Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	$200 Person/$400 Family - Embedded	None
Co-insurance	10% Person/10% Family	None
Annual Out-of-Pocket Maximum	$2,600 Person/$5,200 Family - Embedded	None
Primary Care Physician Office Visits	$5 copay*	First 3 PCP or MH/SA Visits Not Subject to DD
Specialist Office Visits	$30 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: $5 copay*/Spec: $30 copay*	None
Diagnostic X-ray	PCP: $5 copay*/Spec: $30 copay*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: $100 copay*/Free-Stnd: $100 copay*	Prior authorization is required for some services
Rehabilitative Services (PT/OT/ST)	$7 copay*	30 combined PT/OT/ST visits per year. Speech/Occupational Therapy follows Specialist cost share
Allergy Services	$30 copay*	None
Chemotherapy Visit	$30 copay*	None
Inpatient Services - Hospital		
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
Outpatient Hospital Services		
Hospital Rehab Services (OT/ST)	$30 copay*	30 combined PT/OT/ST visits per year.
Hospital Rehab Services (PT)	$7 copay*	30 combined PT/OT/ST visits per year.
Diagnostic Laboratory Services	$30 copay*	None
Diagnostic X-ray	$30 copay*	None
Advanced Imaging Services (CT/PET, scans, MRIs)	$100 copay*	Prior authorization is required for some services
Ambulatory/Outpatient Surgery	$200 copay*	Prior authorization is required for some services
Emergency Care		
Emergency Room (ER) Visit	$50 copay*	None
Urgent Care Centers	$30 copay*	None
Ambulance (Emergency Medical Transportation)	$50 copay*	None
Maternity Services		
Maternity – Prenatal Care	$5 copay*	None
Maternity – Physician Delivery	10% coinsurance*	None
Maternity – Inpatient Hospital Services	10% coinsurance*	None

*Deductible applies to this benefit

Vermont
Plan Name: MVP VT Plus Silver 1 87
Plan Form: FRVT-HMO-S1-002-N (2023)
Plan Status: Active

	Coverage Information	Limits and Exclusions
Behavioral Health Services		
Mental Health Inpatient Hospital	10% coinsurance*	None
Mental Health Outpatient	$5 copay*	First 3 PCP or MH/SA Visits Not Subject to DD
Substance Use Disorder Inpatient Hospital	10% coinsurance*	None
Substance Use Disorder Outpatient	$5 copay*	First 3 PCP or MH/SA Visits Not Subject to DD
Residential Treatment	10% coinsurance*	None
Other Services		
Physician Administered Drugs	20% coinsurance*	None
Skilled Nursing Facility	10% coinsurance*	None
Home Health Care	$30 copay*	None
Hospice	Inpt: 10% coinsurance* / Outpt: $30 copay*	None
Durable Medical Equipment	10% coinsurance*	Prior authorization is required for some items
Diabetic Supplies & Equipment	40% coinsurance*	Prior authorization is required for some items
Chiropractic Benefit	$7 copay*	No visit limit for Chiropractic Care.
Acupuncture	$500 allowance	None
Prescription Drug Coverage		
Tier 1	30 day supply: $5 copay*/90 day supply: $12.50 copay*	VBID 30 day supply $1/90 day supply $2.50
Tier 2	20% coinsurance*	VBID 30 day supply $1/90 day supply $2.50. Prior authorization required for some prescriptions
Tier 3	40% coinsurance*	VBID 30 day supply $1/90 day supply $2.50. Prior authorization required for some prescriptions. Includes Diabetic Supplies and Equipment
Prescription Drug Deductible	$200 Person/$400 Family	None
Prescription Out-of-Pocket Maximum	$700 Person/$1,400 Family - Embedded	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
	Visit mvphealthcare.com 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**.

Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and counties.

***Deductible applies to this benefit**