

# Vermont

Plan Name: MVP VT Plus Silver 1 94

Plan Form: FRVT-HMO-S1-003-N (2023)

Plan Status: Active



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$0 Person/\$0 Family - Embedded	None
Co-insurance	5% Person/5% Family	None
Annual Out-of-Pocket Maximum	\$1,650 Person/\$3,300 Family - Embedded	None
Primary Care Physician Office Visits	\$5 copay	None
Specialist Office Visits	\$10 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: \$5 copay/Spec: \$10 copay	None
Diagnostic X-ray	PCP: \$5 copay/Spec: \$10 copay	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: \$25 copay/Free-Stnd: \$25 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	\$10 copay	None
Chemotherapy Visit	\$10 copay	None
<b>Inpatient Services - Hospital</b>		
Medical/Surgical Admissions	5% coinsurance	Prior authorization is required for some services
Surgical Services	5% coinsurance	Prior authorization is required for some services
Inpatient Physical Rehabilitation	5% coinsurance	None
<b>Outpatient Hospital Services</b>		
Hospital Rehab Services (OT/ST)	\$10 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	\$10 copay	None
Diagnostic X-ray	\$10 copay	None
Advanced Imaging Services (CT/PET, scans, MRIs)	\$25 copay	Prior authorization is required for some services
Ambulatory/Outpatient Surgery	\$45 copay	Prior authorization is required for some services
<b>Emergency Care</b>		
Emergency Room (ER) Visit	\$25 copay	None
Urgent Care Centers	\$10 copay	None
Ambulance (Emergency Medical Transportation)	\$25 copay	None
<b>Maternity Services</b>		
Maternity – Prenatal Care	\$5 copay	None
Maternity – Physician Delivery	5% coinsurance	None
Maternity – Inpatient Hospital Services	5% coinsurance	None

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	Coverage Information	Limits and Exclusions
<b>Behavioral Health Services</b>		
Mental Health Inpatient Hospital	5% coinsurance	None
Mental Health Outpatient	\$5 copay	None
Substance Use Disorder Inpatient Hospital	5% coinsurance	None
Substance Use Disorder Outpatient	\$5 copay	None
Residential Treatment	5% coinsurance	None
<b>Other Services</b>		
Physician Administered Drugs	20% coinsurance	None
Skilled Nursing Facility	5% coinsurance	None
Home Health Care	\$10 copay	None
Hospice	Inpt: 5% coinsurance / Outpt: \$10 copay	None
Durable Medical Equipment	5% coinsurance	Prior authorization is required for some items
Diabetic Supplies & Equipment	5% coinsurance	Prior authorization is required for some items
Chiropractic Benefit	\$7 copay	No visit limit for Chiropractic Care.
Acupuncture	\$500 allowance	None
<b>Prescription Drug Coverage</b>		
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	5% coinsurance	VBID 30 day supply \$1/90 day supply \$2.50. Prior authorization required for some prescriptions
Tier 3	5% 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	None	None
Prescription Out-of-Pocket Maximum	\$550 Person/\$1,100 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	\$600 allowance	Get reimbursed up to \$600 per contract, per calendar year
	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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