## Vermont

Plan Name: MVP VT Silver 4 HDHP 73 Plan Form: FRVT-HMOH-S4-001-S (2023)

## Plan Status: Active



| Plan Cost-Sharing Highlights     Coverage Information     Limits and Exclusions       Annual Deductible per Contract Year     \$2,000 Person/\$4,000 Family - Aggregate     None       Co-insurance     25% Person/25% Family     None     None       Annual Out-of-Pocket Maximum     \$6,000 Person/\$12,000 Family (Max \$9,100     None       Primary Care Physician Office Visits     25% coinsurance*     None       Specialist Office Visits     25% coinsurance*     None       Preventive & Well Care Services     Covered in Full.     For a full list of covered preventive care services, visit       Well Child Care & Immunizations     Covered in Full.     For a full list of covered preventive care services, visit     None       Preventive & Well Care Services     Covered in Full.     For a full list of covered preventive care services, visit     None       Bone Density Tests     PCP: 10% coinsurance*/Spec: 25%     None     None       Diagnostic Laboratory Services     PCP: 10% coinsurance*/Spec: 25%     None     Prior authorization is required for some service coinsurance*       Advanced Imaging Services (CT/PET scans, MRIs)     Specialis Coinsurance*     Specialis Cost share     30 combined PT/OT/ST visits per year.       Rehabilitative Services     25% coi |
|---|
| Annual Deductible per Contract Year   25% Person/25% Family   None     Co-insurance   25% Person/25% Family   None     Annual Out-of-Pocket Maximum   per family member) - Aggregate   None     Primary Care Physician Office Visits   10% coinsurance*   None     Specialist Office Visits   25% coinsurance*   None     Preventive & Well Care Services   Covered in Full.   For a full list of covered preventive care services, visit   None     Mannual Physical (One per Contract Year)   Covered in Full.   For a full list of covered preventive care services, visit   None     Bone Density Tests   Physician Office Visits   PCP: 10% coinsurance*/Spec: 25%   None     Diagnostic Laboratory Services   PCP: 10% coinsurance*/Spec: 25%   None     Diagnostic X-ray   CO/PCP 10% coinsurance*/Spec: 25%   None     Advanced Imaging Services (PT/OT/ST)   Spec: 25% coinsurance*   30 combined PT/OT/ST visits per year.     Spece./Occupational Therapy follows Specialis cost share   25% coinsurance*   None   |
| Annual Out-of-Pocket Maximum   \$6,000 Person/\$12,000 Family (Max \$9,100 per family member) - Aggregate   None     Primary Care Physician Office Visits   10% coinsurance*   None     Specialist Office Visits   25% coinsurance*   None     Preventive & Well Care Services   Well Child Care & Immunizations   None     Adult Annual Physical (One per Contract Year)   Covered in Full.   For a full list of covered preventive care services, visit   None     Immunizations for Adults   Colonscopy /Sigmoidoscopy Screening   Covered in Full.   For a full list of covered preventive care services, visit   None     Physician Office Visits   PCP: 10% coinsurance*/Spec: 25%   None   None     Diagnostic Laboratory Services   PCP: 10% coinsurance*/Spec: 25%   None     Diagnostic X-ray   Coinsurance*   Spec: 25% coinsurance*/Spec: 25%   None     Advanced Imaging Services (PT/OT/ST)   Spec: 25% coinsurance*/Free-Stnd: 25%   Prior authorization is required for some service coinsurance*     25% coinsurance*   None   Speech/Occupational Therapy follows Specialis cost share  |
| Annual Out-of-Pocket Maximum   per family member) - Aggregate     Primary Care Physician Office Visits   10% coinsurance*   None     Specialist Office Visits   25% coinsurance*   None     Preventive & Well Care Services   25% coinsurance*   None     Well Child Care & Immunizations   Adult Annual Physical (One per Contract Year)   Annual Pap Test & Ob/Gyn Exam   None     Annual Pap Test & Ob/Gyn Exam   For a full list of covered preventive care services, visit   None   None     Bone Density Tests   PCP: 10% coinsurance*/Spec: 25%   None   None     Diagnostic Laboratory Services   PCP: 10% coinsurance*/Spec: 25%   None     Diagnostic X-ray   PCP: 10% coinsurance*/Spec: 25%   None     Advanced Imaging Services (PT/OT/ST)   Spec: 25% coinsurance*   30 combined PT/OT/ST visits per year.     Rehabilitative Services (PT/OT/ST)   25% coinsurance*   None   |
| Primary Care Physician Office Visitsper family member) - AggregateSpecialist Office Visits10% coinsurance*NoneSpecialist Office Visits25% coinsurance*NoneWell Child Care & Immunizations<br>Adult Annual Physical (One per Contract Year)<br>Mammography<br>Annual Pap Test & Ob/Gyn Exam<br>Immunizations for Adults<br>Colonscopy /Sigmoidoscopy Screening<br>Bone Density TestsCovered in Full.<br>For a full list of covered preventive care<br>services, visit<br>myphealthcare.com,NonePhysician Office VisitsPCP: 10% coinsurance*/Spec: 25%<br>coinsurance*NoneDiagnostic Laboratory ServicesPCP: 10% coinsurance*/Spec: 25%<br>coinsurance*NoneDiagnostic X-raySpec: 25% coinsurance*/Spec: 25%<br>coinsurance*NoneAdvanced Imaging Services (PT/OT/ST)Spec: 25% coinsurance*30 combined PT/OT/ST visits per year.<br>Spec: advision specialis<br>cost shareRehabilitative Services (PT/OT/ST)25% coinsurance*None  |
| Specialist Office Visits   25% coinsurance*   None     Preventive & Well Care Services   Vell Child Care & Immunizations   Adult Annual Physical (One per Contract Year)     Mammography   Annual Pap Test & Ob/Gyn Exam   For a full list of covered preventive care services, visit   None     Immunizations for Adults   Covered in Full.   For a full list of covered preventive care services, visit   None     Bone Density Tests   Physician Office Visits   PCP: 10% coinsurance*/Spec: 25% coinsurance*   None     Diagnostic Laboratory Services   PCP: 10% coinsurance*/Spec: 25% coinsurance*   None     Diagnostic X-ray   PCP: 10% coinsurance*/Spec: 25% coinsurance*   Prior authorization is required for some service coinsurance*     Advanced Imaging Services (PT/OT/ST)   Spec: 25% coinsurance*   30 combined PT/OT/ST visits per year.     Spec: 25% coinsurance*   Spec: Stare   30 combined PT/OT/ST visits per year.     Specialis cost share   Specialis cost share   Specialis cost share  |
| 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     Physician Office Visits     Diagnostic Laboratory Services     Diagnostic X-ray     Advanced Imaging Services (CT/PET scans, MRIs)     Rehabilitative Services (PT/OT/ST)     Z5% coinsurance*     None     25% coinsurance*     None  |
| 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     Physician Office Visits     Diagnostic Laboratory Services     Diagnostic X-ray     Advanced Imaging Services (CT/PET scans, MRIs)     Rehabilitative Services (PT/OT/ST)     Z5% coinsurance*     None     None     Spec: 25% coinsurance*     Spech/Occupational Therapy follows Specialis cost share   |
| Adult Annual Physical (One per Contract Year)   Covered in Full.   For a full list of covered preventive care services, visit   None     Annual Pap Test & Ob/Gyn Exam   Immunizations for Adults   None   None     Colonoscopy /Sigmoidoscopy Screening   Bone Density Tests   PCP: 10% coinsurance*/Spec: 25%   None     Physician Office Visits   PCP: 10% coinsurance*/Spec: 25%   None     Diagnostic Laboratory Services   PCP: 10% coinsurance*/Spec: 25%   None     Diagnostic X-ray   PCP: 10% coinsurance*/Spec: 25%   None     Advanced Imaging Services (CT/PET scans, MRIs)   Spec: 25% coinsurance*   Prior authorization is required for some service     Rehabilitative Services (PT/OT/ST)   25% coinsurance*   30 combined PT/OT/ST visits per year.     Specch/Occupational Therapy follows Specialis cost share   Spech/Occupational Therapy follows Specialis  |
| Mammography<br>Annual Pap Test & Ob/Gyn Exam<br>Immunizations for Adults<br>Colonoscopy /Sigmoidoscopy Screening<br>Bone Density TestsCovered in Full.<br>For a full list of covered preventive care<br>services, visit<br>myphealthcare.com.NonePhysician Office VisitsPCP: 10% coinsurance*/Spec: 25%<br>coinsurance*NoneDiagnostic Laboratory ServicesPCP: 10% coinsurance*/Spec: 25%<br>coinsurance*NoneDiagnostic X-rayPCP: 10% coinsurance*/Spec: 25%<br>coinsurance*NoneAdvanced Imaging Services (CT/PET scans, MRIs)Spec: 25% coinsurance*Prior authorization is required for some service<br>coinsurance*Rehabilitative Services (PT/OT/ST)25% coinsurance*None   |
| Maininggraphy   For a full list of covered preventive care services, visit   None     Immunizations for Adults   Colonoscopy /Sigmoidoscopy Screening   None     Bone Density Tests   Physician Office Visits   PCP: 10% coinsurance*/Spec: 25%   None     Diagnostic Laboratory Services   PCP: 10% coinsurance*/Spec: 25%   None     Diagnostic X-ray   PCP: 10% coinsurance*/Spec: 25%   None     Advanced Imaging Services (CT/PET scans, MRIs)   Spec: 25% coinsurance*   Prior authorization is required for some service     Rehabilitative Services (PT/OT/ST)   25% coinsurance*   30 combined PT/OT/ST visits per year.     Speech/Occupational Therapy follows Specialis cost share   Specialis cost share   |
| Annual Pap Test & Ob/Gyn Exam   services, visit   Inone     Immunizations for Adults   myphealthcare.com.   None     Colonoscopy /Sigmoidoscopy Screening   Physician Office Visits   PCP: 10% coinsurance*/Spec: 25%   None     Diagnostic Laboratory Services   PCP: 10% coinsurance*/Spec: 25%   None     Diagnostic X-ray   PCP: 10% coinsurance*/Spec: 25%   None     Advanced Imaging Services (CT/PET scans, MRIs)   Spec: 25% coinsurance*   Prior authorization is required for some service coinsurance*     Rehabilitative Services (PT/OT/ST)   25% coinsurance*   30 combined PT/OT/ST visits per year.     Speech/Occupational Therapy follows Specialis cost share   25% coinsurance*   None   |
| Colonoscopy /Sigmoidoscopy Screening<br>Bone Density TestsImvpneatmcare.com.Physician Office VisitsPCP: 10% coinsurance*/Spec: 25%<br>coinsurance*NoneDiagnostic Laboratory ServicesPCP: 10% coinsurance*/Spec: 25%<br>coinsurance*NoneDiagnostic X-rayPCP: 10% coinsurance*/Spec: 25%<br>coinsurance*NoneAdvanced Imaging Services (CT/PET scans, MRIs)Spec: 25% coinsurance*/Free-Stnd: 25%<br>coinsurance*Prior authorization is required for some service<br>coinsurance*Rehabilitative Services (PT/OT/ST)25% coinsurance*30 combined PT/OT/ST visits per year.<br>Specialis<br>cost share   |
| Bone Density Tests   Physician Office Visits   PCP: 10% coinsurance*/Spec: 25%   None     Diagnostic Laboratory Services   PCP: 10% coinsurance*/Spec: 25%   None     Diagnostic X-ray   PCP: 10% coinsurance*/Spec: 25%   None     Advanced Imaging Services (CT/PET scans, MRIs)   Spec: 25% coinsurance*   Prior authorization is required for some service     Rehabilitative Services (PT/OT/ST)   25% coinsurance*   30 combined PT/OT/ST visits per year.     Speech/Occupational Therapy follows Specialis cost share   Sot share   |
| Physician Office Visits   PCP: 10% coinsurance*/Spec: 25%   None     Diagnostic Laboratory Services   PCP: 10% coinsurance*/Spec: 25%   None     Diagnostic X-ray   PCP: 10% coinsurance*/Spec: 25%   None     Advanced Imaging Services (CT/PET scans, MRIs)   Spec: 25% coinsurance*/Free-Stnd: 25%   Prior authorization is required for some service     Rehabilitative Services (PT/OT/ST)   25% coinsurance*   30 combined PT/OT/ST visits per year.     Spec: 25% coinsurance*   Spech/Occupational Therapy follows Specialis cost share     25% coinsurance*   None   |
| Diagnostic Laboratory Services   PCP: 10% coinsurance*/Spec: 25%   None     Diagnostic X-ray   PCP: 10% coinsurance*/Spec: 25%   None     Advanced Imaging Services (CT/PET scans, MRIs)   Spec: 25% coinsurance*/Free-Stnd: 25%   Prior authorization is required for some service     Rehabilitative Services (PT/OT/ST)   25% coinsurance*   30 combined PT/OT/ST visits per year.     Spec: 25% coinsurance*   Specch/Occupational Therapy follows Specialis cost share   |
| Diagnostic Laboratory Services   coinsurance*   None     Diagnostic X-ray   PCP: 10% coinsurance*/Spec: 25%   None     Advanced Imaging Services (CT/PET scans, MRIs)   Spec: 25% coinsurance*/Free-Stnd: 25%   Prior authorization is required for some service     Rehabilitative Services (PT/OT/ST)   25% coinsurance*   30 combined PT/OT/ST visits per year.     Spec: 25% coinsurance*   Spech/Occupational Therapy follows Specialis cost share     25% coinsurance*   None   |
| Diagnostic X-ray   PCP: 10% coinsurance*/Spec: 25%   None     Advanced Imaging Services (CT/PET scans, MRIs)   Spec: 25% coinsurance*/Free-Stnd: 25%   Prior authorization is required for some service     Rehabilitative Services (PT/OT/ST)   25% coinsurance*   30 combined PT/OT/ST visits per year.     Spec: 25% coinsurance*   Spec: 000000000000000000000000000000000000   |
| Diagnostic X-ray   coinsurance*   Prior authorization is required for some service     Advanced Imaging Services (CT/PET scans, MRIs)   Spec: 25% coinsurance*/Free-Stnd: 25%<br>coinsurance*   Prior authorization is required for some service     Rehabilitative Services (PT/OT/ST)   25% coinsurance*   30 combined PT/OT/ST visits per year.     Spec: 25% coinsurance*   Spec: 25% coinsurance*   Spec: 25% coinsurance*     None   25% coinsurance*   Spec: 25% coinsurance*  |
| Advanced Imaging Services (CT/PET scans, MRIs)   coinsurance*   30 combined PT/OT/ST visits per year.     Rehabilitative Services (PT/OT/ST)   25% coinsurance*   30 combined PT/OT/ST visits per year.     25% coinsurance*   Speech/Occupational Therapy follows Specialis cost share     25% coinsurance*   None   |
| Rehabilitative Services (PT/OT/ST)   25% coinsurance*   30 combined PT/OT/ST visits per year.     25% coinsurance*   Speech/Occupational Therapy follows Specialis cost share     25% coinsurance*   None   |
| Rehabilitative Services (PT/OT/ST)   Speech/Occupational Therapy follows Specialis cost share     25% coinsurance*   None   |
| Rehabilitative Services (PT/OT/ST) cost share   25% coinsurance* None   |
| 25% coinsurance* None   |
|   |
|   |
| Allergy Services  |
|   |
| Chemotherapy Visit 25% coinsurance* None  |
| Inpatient Services - Hospital   |
| Medical/Surgical Admissions     25% coinsurance*     Prior authorization is required for some service   |
|   |
| Surgical Services 25% coinsurance* Prior authorization is required for some service   |
|   |
| Inpatient Physical Rehabilitation 25% coinsurance* None   |
| Outpatient Hospital Services 30 combined PT/QT/ST visits per year   Hospital Rehab Services (QT/ST) 25% coinsurance* 30 combined PT/QT/ST visits per year   |
|   |
|   |
| Diagnostic Laboratory Services 25% coinsurance* None   Diagnostic X-ray 25% coinsurance* None   |
| Diagnostic X-ray     25% coinsurance*     None       Advanced Imaging Services (CT/PET, scans, MRIs)     25% coinsurance*     Prior authorization is required for some service  |
| Advanced inlaging Services (cr) is is called, with share     25% consultance     Prior authorization is required for some service       Ambulatory/Outpatient Surgery     25% consurance*     Prior authorization is required for some service  |
| Emergency Care  |
| Emergency Room (ER) Visit 25% coinsurance* None   |
| Urgent Care Centers 25% coinsurance* None   |
| Ambulance (Emergency Medical Transportation) 25% coinsurance* None  |
|   |
| Matorpity Sonvicos  |
| Maternity Services  |
| Maternity Services None   Maternity - Prenatal Care 10% coinsurance* None   |
| Maternity – Prenatal Care 10% coinsurance* None   |
| 10% coinsurance* None   |

## Vermont

Plan Name: MVP VT Silver 4 HDHP 73 Plan Form: FRVT-HMOH-S4-001-S (2023) Plan Status: Active



| i lan Blatas. / letive                    |   | HEALTH CARE  |
|---|---|--|
|   | Coverage Information                                      | Limits and Exclusions  |
| Behavioral Health Services                |   |  |
| Mental Health Inpatient Hospital          | 25% coinsurance*  | None   |
| Mental Health Outpatient                  | 10% coinsurance*  | None   |
| Substance Use Disorder Inpatient Hospital | 25% coinsurance*  | None   |
| Substance Use Disorder Outpatient         | 10% coinsurance*  | None   |
| Residential Treatment                     | 25% coinsurance*  | None   |
| Other Services                            |   |  |
| Physician Administered Drugs              | 25% coinsurance*  | None   |
| Skilled Nursing Facility                  | 25% coinsurance*  | None   |
| Home Health Care                          | 25% coinsurance*  | None   |
| Hospice                                   | 25% coinsurance*  | None   |
| Durable Medical Equipment                 | 25% coinsurance*  | Prior authorization is required for some items   |
| Diabetic Supplies & Equipment             | 50% coinsurance*  | Prior authorization is required for some items   |
| Chiropractic Benefit                      | 25% coinsurance*  | No visit limit for Chiropractic Care   |
| Acupuncture                               | Not covered   | None   |
| Prescription Drug Coverage                |   |  |
| Tier 1                                    | 30 day supply: \$10 copay*/90 day supply:<br>\$25 copay*  | Preventive drugs deductible waived   |
| Tier 2                                    | 30 day supply: \$40 copay*/90 day supply:<br>\$100 copay* | Preventive drugs deductible waived. Prior authorization is required for some prescriptions   |
| Tier 3                                    | 50% coinsurance*  | Preventive drugs deductible waived. Prior authorization is required for some prescriptions. Includes Diabetic Supplies and Equipment |
| Prescription Drug Deductible              | Subject to annual deductible                              | None   |
| Prescription Out-of-Pocket Maximum        | \$1,500 Person/\$3,000 Family - Aggregate                 | 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                         | 0% coinsurance  | None   |
| Wellness Benefits                         | Not covered   | None   |
|   | -   | on. View a complete Glossary of Terms and Member FAQs to   |

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**.

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