

**Vermont**

**Plan Name:** MVP VT Plus Gold 3 AI-AN U300%

**Plan Form:** FRVT-HMOH-GA1-003-N (2024)

**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	As Noted Below	None
Annual Out-of-Pocket Maximum	\$0 Person/\$0 Family - Embedded	None
Primary Care Physician Office Visits	Covered in Full	None
Specialist Office Visits	Covered in Full	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	Covered in Full	None
Diagnostic X-ray	Covered in Full	None
Advanced Imaging Services (CT/PET scans, MRIs)	Covered in Full	Prior authorization is required for some services
Rehabilitative Services (PT/OT/ST)	Covered in Full	30 combined PT/OT/ST visits per year
Allergy Services	Covered in Full	None
Chemotherapy Visit	Covered in Full	None
<b>Inpatient Services - Hospital</b>		
Medical/Surgical Admissions	Covered in Full	Prior authorization is required for some services
Surgical Services	Covered in Full	Prior authorization is required for some services
Inpatient Physical Rehabilitation	Covered in Full	None
<b>Outpatient Hospital Services</b>		
Hospital Rehab Services (OT/ST)	Covered in Full	30 combined PT/OT/ST visits per year
Hospital Rehab Services (PT)	Covered in Full	30 combined PT/OT/ST visits per year
Diagnostic Laboratory Services	Covered in Full	None
Diagnostic X-ray	Covered in Full	None
Advanced Imaging Services (CT/PET, scans, MRIs)	Covered in Full	Prior authorization is required for some services
Ambulatory/Outpatient Surgery	Covered in Full	Prior authorization is required for some services
<b>Emergency Care</b>		
Emergency Room (ER) Visit	Covered in Full	None
Urgent Care Centers	Covered in Full	None
Ambulance (Emergency Medical Transportation)	Covered in Full	None
<b>Maternity Services</b>		
Maternity – Prenatal Care	Covered in Full	None
Maternity – Physician Delivery	Covered in Full	None
Maternity – Inpatient Hospital Services	Covered in Full	None

\*Deductible applies to this benefit



	Coverage Information	Limits and Exclusions
<b>Behavioral Health Services</b>		
<b>Mental Health Inpatient Hospital</b>	Covered in Full	None
<b>Mental Health Outpatient</b>	Covered in Full	None
<b>Substance Use Disorder Inpatient Hospital</b>	Covered in Full	None
<b>Substance Use Disorder Outpatient</b>	Covered in Full	None
<b>Residential Treatment</b>	Covered in Full	None
<b>Other Services</b>		
<b>Physician Administered Drugs</b>	Covered in Full	None
<b>Skilled Nursing Facility</b>	Covered in Full	None
<b>Home Health Care</b>	Covered in Full	None
<b>Hospice</b>	Covered in Full	None
<b>Durable Medical Equipment</b>	Covered in Full	Prior authorization is required for some items
<b>Diabetic Supplies &amp; Equipment</b>	Covered in Full	Prior authorization is required for some items
<b>Chiropractic Benefit</b>	Covered in Full	No visit limit for Chiropractic Care
<b>Acupuncture</b>	\$500 allowance	None
<b>Prescription Drug Coverage</b>		
<b>Tier 1</b>	Covered in Full	None
<b>Tier 2</b>	Covered in Full	Prior authorization is required for some prescriptions
<b>Tier 3</b>	Covered in Full	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>	\$0 Person/\$0 Family	None
<b>Vision Care</b>		
<b>Adult Vision Care</b>	Not covered	None
<b>Pediatric Vision Care</b>	Covered in Full	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>	\$600 allowance	Get reimbursed up to \$600 per contract, per calendar year
	Visit <a href="http://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](http://mvphealthcare.com).

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