Vermont

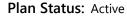
Plan Name:MVP VT Plus Gold 3 HDHP AI-ANPlan Form:FRVT-HMOH-GA2-003-N (2024)

Plan Status: Active



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$3,000 Person/\$6,000 Family - Aggregate	None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	\$3,000 Person/\$6,000 Family - Aggregate	None
Primary Care Physician Office Visits	0% coinsurance*	None
Specialist Office Visits	0% coinsurance*	None
Preventive & Well Care Services		
Well Child Care & Immunizations		
Adult Annual Physical (One per Contract Year)		
Mammography	Covered in Full. For a full list of covered preventive care	
Annual Pap Test & Ob/Gyn Exam	services, visit	None
Immunizations for Adults	mvphealthcare.com	
Colonoscopy /Sigmoidoscopy Screening		
Bone Density Tests		
Physician Office Visits	PCP: 0% coinsurance*/Spec: 0% coinsurance*	None
Diagnostic Laboratory Services	FCF. 0% consulance /spec. 0% consulance	None
	PCP: 0% coinsurance*/Spec: 0% coinsurance*	None
Diagnostic X-ray	PCP. 0% consurance /spec. 0% consurance	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 0% coinsurance*/Free-Stnd: 0%	Prior authorization is required for some services
Advanced imaging Services (CT/FET scalls, WRIS)	coinsurance*	
	0% coinsurance*	30 combined PT/OT/ST visits per year.
		Speech/Occupational Therapy follows Specialist
Rehabilitative Services (PT/OT/ST)		cost share
	0% coinsurance*	None
Allergy Services		
Chemotherapy Visit	0% coinsurance*	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	0% coinsurance*	Prior authorization is required for some services
Surgical Services	0% coinsurance*	Prior authorization is required for some services
Inpatient Physical Rehabilitation	0% coinsurance*	None
Outpatient Hospital Services		
Hospital Rehab Services (OT/ST)	0% coinsurance*	30 combined PT/OT/ST visits per year
Hospital Rehab Services (PT)	0% coinsurance*	30 combined PT/OT/ST visits per year
Diagnostic Laboratory Services	0% coinsurance*	None
Diagnostic X-ray	0% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)	0% coinsurance*	Prior authorization is required for some services
Ambulatory/Outpatient Surgery	0% coinsurance*	Prior authorization is required for some services
Emergency Care		
Emergency Room (ER) Visit	0% coinsurance*	None
Urgent Care Centers	0% coinsurance*	None
Ambulance (Emergency Medical Transportation)	0% coinsurance*	None
Maternity Services		
Maternity – Prenatal Care	0% coinsurance*	None
Maternity – Physician Delivery	0% coinsurance*	None
Maternity – Inpatient Hospital Services	0% coinsurance*	None

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	Coverage Information	Limits and Exclusions
Behavioral Health Services		
Mental Health Inpatient Hospital	0% coinsurance*	None
Mental Health Outpatient	0% coinsurance*	None
Substance Use Disorder Inpatient Hospital	0% coinsurance*	None
Substance Use Disorder Outpatient	0% coinsurance*	None
Residential Treatment	0% coinsurance*	None
Other Services		
Physician Administered Drugs	0% coinsurance*	None
Skilled Nursing Facility	0% coinsurance*	None
Home Health Care	0% coinsurance*	None
Hospice	0% coinsurance*	None
Durable Medical Equipment	0% coinsurance*	Prior authorization is required for some items
Diabetic Supplies & Equipment	0% coinsurance*	Prior authorization is required for some items
Chiropractic Benefit	0% coinsurance*	No visit limit for Chiropractic Care
Acupuncture	\$500 allowance*	None
Prescription Drug Coverage		
Tier 1	0% coinsurance*	Preventive drugs 30 day supply \$10; 90 day supply \$25, deductible waived
Tier 2	0% coinsurance*	Preventive drugs 30 day supply \$15; 90 day supply \$37.50, DD Waived. Prior authorization is required for some
Tier 3	0% coinsurance*	 prescriptions Preventive drugs 30 day/90 supply 5% 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	\$1,600 Person/\$3,200 Family - Aggregate	None
Vision Care		
Adult Vision Care	Not covered	None
Pediatric Vision Care	-	One eye exam per year to age 21
	0% coinsurance*	One eye exam per year to age 21
Other Plan Features		None
Gia® Virtual Care	0% coinsurance	None
Wellness Benefits	\$600 allowance	Get reimbursed up to \$600 per contract, per calendar year
		on. 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.