**Vermont**
**Plan Name:** MVP VT Platinum 1
**Plan Form:** FRVT-HMO-SP-001-S (2024)
**Plan Status:** Active

| Plan Cost-Sharing Highlights | Coverage Information | Limits and Exclusions |
|---|---|---|
| Annual Deductible per Contract Year | $450 Person/$900 Family - Embedded | None |
| Co-insurance | 10% Person/10% Family | None |
| Annual Out-of-Pocket Maximum | $1,500 Person/$3,000 Family - Embedded | None |
| Primary Care Physician Office Visits | $15 copay | First 3 PCP or MH/SA Visits Covered in Full |
| Specialist Office Visits | $40 copay | None |
| **Preventive & Well Care Services** | | |
| Well 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>Colonoscopy /Sigmoidoscopy Screening<br>Bone Density Tests | Covered in Full.<br>For a full list of covered preventive care services, visit mvphealthcare.com. | None |
| **Physician Office Visits** | | |
| Diagnostic Laboratory Services | PCP: $15 copay/Spec: $40 copay | None |
| Diagnostic X-ray | PCP: $15 copay/Spec: $40 copay | None |
| Advanced Imaging Services (CT/PET scans, MRIs) | Spec: 10% coinsurance*/Free-Stnd: 10% coinsurance* | Prior authorization is required for some services |
| Rehabilitative Services (PT/OT/ST) | $20 copay | 30 combined PT/OT/ST visits per year.<br>Speech/Occupational Therapy follows Specialist cost share |
| Allergy Services | $40 copay | None |
| Chemotherapy Visit | $40 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) | 10% coinsurance* | 30 combined PT/OT/ST visits per year. |
| Hospital Rehab Services (PT) | $20 copay | 30 combined PT/OT/ST visits per year. |
| Diagnostic Laboratory Services | 10% coinsurance* | None |
| Diagnostic X-ray | 10% coinsurance* | None |
| Advanced Imaging Services (CT/PET, scans, MRIs) | 10% coinsurance* | Prior authorization is required for some services |
| Ambulatory/Outpatient Surgery | 10% coinsurance* | Prior authorization is required for some services |
| **Emergency Care** | | |
| Emergency Room (ER) Visit | $100 copay* | None |
| Urgent Care Centers | $50 copay | None |
| Ambulance (Emergency Medical Transportation) | $60 copay | None |
| **Maternity Services** | | |
| Maternity – Prenatal Care | $15 copay | None |
| Maternity – Physician Delivery | 10% coinsurance* | None |
| Maternity – Inpatient Hospital Services | 10% coinsurance* | None |

*Deductible applies to this benefit

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| | Coverage Information | Limits and Exclusions |
|---|---|---|
| **Behavioral Health Services** | | |
| Mental Health Inpatient Hospital | 10% coinsurance* | None |
| Mental Health Outpatient | $15 copay | First 3 PCP or MH/SA Visits Covered in Full |
| Substance Use Disorder Inpatient Hospital | 10% coinsurance* | None |
| Substance Use Disorder Outpatient | $15 copay | First 3 PCP or MH/SA Visits Covered in Full |
| Residential Treatment | 10% coinsurance* | None |
| **Other Services** | | |
| Physician Administered Drugs | 10% coinsurance* | None |
| Skilled Nursing Facility | 10% coinsurance* | None |
| Home Health Care | 10% coinsurance* | None |
| Hospice | 10% coinsurance* | None |
| Durable Medical Equipment | 10% coinsurance* | Prior authorization is required for some items |
| Diabetic Supplies & Equipment | 50% coinsurance | Prior authorization is required for some items |
| Chiropractic Benefit | $20 copay | No visit limit for Chiropractic Care. |
| Acupuncture | Not covered | None |
| **Prescription Drug Coverage** | | |
| Tier 1 | 30 day supply: $10 copay/90 day supply: $25 copay | None |
| Tier 2 | 30 day supply: $50 copay/90 day supply: $125 copay | Prior authorization is required for some prescriptions |
| Tier 3 | 50% coinsurance | Prior authorization is required for some prescriptions. Includes Diabetic Supplies and Equipment |
| Prescription Drug Deductible | None | None |
| Prescription Out-of-Pocket Maximum | $1,500 Person/$3,000 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 | Not covered | None |
| | 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**