Vermont
Plan Name: MVP VT Plus Silver 1
Plan Form: FRVT-HMO-SS-001-N (2024)
Plan Status: Active

Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	$2,500 Person/$5,000 Family - Embedded	None
Co-insurance	50% Person/50% Family	None
Annual Out-of-Pocket Maximum	$7,500 Person/$15,000 Family - Embedded	None
Primary Care Physician Office Visits	$30 copay*	First 3 PCP or MH/SA Visits Not Subject to DD
Specialist Office Visits	$60 copay*	None
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	Covered in Full. For a full list of covered preventive care services, visit **mvphealthcare.com**.	None
Physician Office Visits		
Diagnostic Laboratory Services	PCP: $30 copay*/Spec: $60 copay*	None
Diagnostic X-ray	PCP: $30 copay*/Spec: $60 copay*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: $1400 copay*/Free-Stnd: $1400 copay*	Prior authorization is required for some services
Rehabilitative Services (PT/OT/ST)	$45 copay*	30 combined PT/OT/ST visits per year. Speech/Occupational Therapy follows Specialist cost share
Allergy Services	$60 copay*	None
Chemotherapy Visit	$60 copay*	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	50% coinsurance*	Prior authorization is required for some services
Surgical Services	50% coinsurance*	Prior authorization is required for some services
Inpatient Physical Rehabilitation	50% coinsurance*	None
Outpatient Hospital Services		
Hospital Rehab Services (OT/ST)	$60 copay*	30 combined PT/OT/ST visits per year.
Hospital Rehab Services (PT)	$45 copay*	30 combined PT/OT/ST visits per year.
Diagnostic Laboratory Services	$60 copay*	None
Diagnostic X-ray	$150 copay*	None
Advanced Imaging Services (CT/PET, scans, MRIs)	$1,400 copay*	Prior authorization is required for some services
Ambulatory/Outpatient Surgery	$1,400 copay*	Prior authorization is required for some services
Emergency Care		
Emergency Room (ER) Visit	$400 copay*	None
Urgent Care Centers	$60 copay*	None
Ambulance (Emergency Medical Transportation)	$100 copay*	None
Maternity Services		
Maternity – Prenatal Care	$30 copay*	None
Maternity – Physician Delivery	50% coinsurance*	None
Maternity – Inpatient Hospital Services	50% coinsurance*	None

*Deductible applies to this benefit

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	Coverage Information	Limits and Exclusions
Behavioral Health Services		
Mental Health Inpatient Hospital	50% coinsurance*	None
Mental Health Outpatient	$30 copay*	First 3 PCP or MH/SA Visits Not Subject to DD
Substance Use Disorder Inpatient Hospital	50% coinsurance*	None
Substance Use Disorder Outpatient	$30 copay*	First 3 PCP or MH/SA Visits Not Subject to DD
Residential Treatment	50% coinsurance*	None
Other Services		
Physician Administered Drugs	20% coinsurance*	None
Skilled Nursing Facility	50% coinsurance*	None
Home Health Care	$60 copay*	None
Hospice	Inpt: 50% coinsurance* / Outpt: $60 copay*	None
Durable Medical Equipment	50% coinsurance*	Prior authorization is required for some items
Diabetic Supplies & Equipment	50% coinsurance*	Prior authorization is required for some items
Chiropractic Benefit	$45 copay*	No visit limit for Chiropractic Care.
Acupuncture	$500 allowance	None
Prescription Drug Coverage		
Tier 1	30 day supply: $5 copay*/90 day supply: $12.50 copay*	VBID 30 day supply $1/90 day supply $2.50. $0 generics to age 10
Tier 2	50% coinsurance*	VBID 30 day supply $1/90 day supply $2.50. Prior authorization required for some prescriptions
Tier 3	50% 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	$850 Person/$1,700 Family	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	$600 allowance	Get reimbursed up to $600 per contract, per calendar year
	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**