Vermont
Plan Name: MVP VT Plus Gold 4
Plan Form: FRVT-HMO-G-004-N (2026)
Plan Status: Active

| | Coverage Information | Limits and Exclusions |
|---|---|---|
| Annual Deductible per Contract Year | $5,000 Person/$10,000 Family - Embedded | None |
| Co-insurance | 20% Person/20% Family | None |
| Annual Out-of-Pocket Maximum | $8,000 Person/$16,000 Family - Embedded | None |
| Primary Care Physician Office Visits | Covered in Full | None |
| Specialist Office Visits | Covered in Full | 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 | Covered in Full | None |
| Diagnostic X-ray | Covered in Full | None |
| Advanced Imaging Services (CT/PET scans, MRIs) | Spec: $500 copay*/Free-Stnd: $500 copay* | Prior authorization is required for some services |
| Rehabilitative Services (PT/OT/ST) | $25 copay | 30 combined PT/OT/ST visits per year. Speech/Occupational Therapy follows Specialist cost share |
| Allergy Services | Covered in Full | None |
| Chemotherapy Visit | Covered in Full | Covered in Full |
| **Inpatient Services - Hospital** | | |
| Medical/Surgical Admissions | 20% coinsurance* | Prior authorization is required for some services |
| Surgical Services | 20% coinsurance* | Prior authorization is required for some services |
| Inpatient Physical Rehabilitation | 20% coinsurance* | None |
| **Outpatient Hospital Services** | | |
| Hospital Rehab Services (OT/ST) | $50 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 | Covered in Full | None |
| Diagnostic X-ray | $50 copay | None |
| Advanced Imaging Services (CT/PET, scans, MRIs) | $500 copay* | Prior authorization is required for some services |
| Ambulatory/Outpatient Surgery | $1,000 copay* | Prior authorization is required for some services |
| **Emergency Care** | | |
| Emergency Room (ER) Visit | $500 copay* | None |
| Urgent Care Centers | Covered in Full | None |
| Ambulance (Emergency Medical Transportation) | $150 copay* | None |
| **Maternity Services** | | |
| Maternity – Prenatal Care | Covered in Full | None |
| Maternity – Physician Delivery | 20% coinsurance* | None |
| Maternity – Inpatient Hospital Services | 20% coinsurance* | None |

*Deductible applies to this benefit

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| **Behavioral Health Services** | | |
| Mental Health Inpatient Hospital | 20% coinsurance* | None |
| Mental Health Outpatient | Covered in Full | None |
| Substance Use Disorder Inpatient Hospital | 20% coinsurance* | None |
| Substance Use Disorder Outpatient | Covered in Full | None |
| Residential Treatment | 50% coinsurance* | None |
| **Other Services** | | |
| Physician Administered Drugs | 20% coinsurance* | None |
| Skilled Nursing Facility | 20% coinsurance* | None |
| Home Health Care | $50 copay* | None |
| Hospice | 20% coinsurance* | None |
| Durable Medical Equipment | 20% coinsurance* | Prior authorization is required for some items |
| Diabetic Supplies & Equipment | $80 copay | Prior authorization is required for some items |
| Chiropractic Benefit | $25 copay | No visit limit for Chiropractic Care. |
| Acupuncture | $500 allowance | None |
| **Prescription Drug Coverage** | | |
| Tier 1 | Covered in Full | None |
| Tier 2 | 30 day supply: $40 copay*/90 day supply: $100 copay* | Prior authorization required for some prescriptions |
| Tier 3 | 30 day supply: $80 copay*/90 day supply: $200 copay* | Prior authorization required for some prescriptions.<br>Includes Diabetic Supplies and Equipment |
| Prescription Drug Deductible | Rx Brand - $250 individual / $500 family | None |
| Prescription Out-of-Pocket Maximum | Integrated with medical | 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 | None |
| | Specialty virtual care providers included in Gia may be subject to the plan's applicable 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