Vermont
Plan Name: MVP VT Gold 1
Plan Form: FRVT-HMO-SG-001-S (2026)
Plan Status: Active

Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	$1,500 Person/$3,000 Family - Embedded	None
Co-insurance	30% Person/30% Family	None
Annual Out-of-Pocket Maximum	$5,700 Person/$11,400 Family - Embedded	None
Primary Care Physician Office Visits	$20 copay	First 3 PCP or MH/SA Visits Covered in Full
Specialist Office Visits	$55 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: $20 copay/Spec: $55 copay	None
Diagnostic X-ray	PCP: $20 copay/Spec: $55 copay	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 30% coinsurance*/Free-Stnd: 30% coinsurance*	Prior authorization is required for some services
Rehabilitative Services (PT/OT/ST)	$35 copay	30 combined PT/OT/ST visits per year. Speech/Occupational Therapy follows Specialist cost share
Allergy Services	$55 copay	None
Chemotherapy Visit	$55 copay	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	30% coinsurance*	Prior authorization is required for some services
Surgical Services	30% coinsurance*	Prior authorization is required for some services
Inpatient Physical Rehabilitation	30% coinsurance*	None
Outpatient Hospital Services		
Hospital Rehab Services (OT/ST)	$55 copay	30 combined PT/OT/ST visits per year.
Hospital Rehab Services (PT)	$35 copay	30 combined PT/OT/ST visits per year.
Diagnostic Laboratory Services	30% coinsurance*	None
Diagnostic X-ray	30% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)	30% coinsurance*	Prior authorization is required for some services
Ambulatory/Outpatient Surgery	30% coinsurance*	Prior authorization is required for some services
Emergency Care		
Emergency Room (ER) Visit	$150 copay*	None
Urgent Care Centers	$65 copay	None
Ambulance (Emergency Medical Transportation)	$75 copay	None
Maternity Services		
Maternity – Prenatal Care	$20 copay	None
Maternity – Physician Delivery	30% coinsurance*	None
Maternity – Inpatient Hospital Services	30% coinsurance*	None

***Deductible applies to this benefit**

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	Coverage Information	Limits and Exclusions
Behavioral Health Services		
Mental Health Inpatient Hospital	30% coinsurance*	None
Mental Health Outpatient	$20 copay	First 3 PCP or MH/SA Visits Covered in Full
Substance Use Disorder Inpatient Hospital	30% coinsurance*	None
Substance Use Disorder Outpatient	$20 copay	First 3 PCP or MH/SA Visits Covered in Full
Residential Treatment	30% coinsurance*	None
Other Services		
Physician Administered Drugs	30% coinsurance*	None
Skilled Nursing Facility	30% coinsurance*	None
Home Health Care	30% coinsurance*	None
Hospice	30% coinsurance*	None
Durable Medical Equipment	30% coinsurance*	Prior authorization is required for some items
Diabetic Supplies & Equipment	50% coinsurance	Prior authorization is required for some items
Chiropractic Benefit	$35 copay	No visit limit for Chiropractic Care.
Acupuncture	Not covered	None
Prescription Drug Coverage		
Tier 1	30 day supply: $15 copay/90 day supply: $37.50 copay	None
Tier 2	30 day supply: $60 copay*/90 day supply: $150 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	Rx Brand - $250 individual / $500 family	None
Prescription Out-of-Pocket Maximum	$1,650 Person/$3,300 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
Plan Highlights	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**.

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***Deductible applies to this benefit**