

**Vermont**  
**Plan Name:** MVP VT Plus Gold 3 HDHP  
**Plan Form:** FRVT-HMOH-SG-003-N (2026)  
**Plan Status:** Active



Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	\$3,200 Person/\$6,400 Family - Aggregate	None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	\$3,200 Person/\$6,400 Family - Aggregate	None
Primary Care Physician Office Visits	0% coinsurance*	None
Specialist Office Visits	0% coinsurance*	None
<b>Preventive &amp; Well Care Services</b>		
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 <a href="http://mvphealthcare.com">mvphealthcare.com</a> .	None
<b>Physician Office Visits</b>		
Diagnostic Laboratory Services	PCP: 0% coinsurance*/Spec: 0% coinsurance*	None
Diagnostic X-ray	PCP: 0% coinsurance*/Spec: 0% coinsurance*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 0% coinsurance*/Free-Stnd: 0% coinsurance*	Prior authorization is required for some services
Rehabilitative Services (PT/OT/ST)	0% coinsurance*	30 combined PT/OT/ST visits per year. Speech/Occupational Therapy follows Specialist cost share
Allergy Services	0% coinsurance*	None
Chemotherapy Visit	0% coinsurance*	None
<b>Inpatient Services - Hospital</b>		
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
<b>Outpatient Hospital Services</b>		
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
<b>Emergency Care</b>		
Emergency Room (ER) Visit	0% coinsurance*	None
Urgent Care Centers	0% coinsurance*	None
Ambulance (Emergency Medical Transportation)	0% coinsurance*	None
<b>Maternity Services</b>		
Maternity – Prenatal Care	0% coinsurance*	None
Maternity – Physician Delivery	0% coinsurance*	None
Maternity – Inpatient Hospital Services	0% coinsurance*	None

\*Deductible applies to this benefit

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<b>Behavioral Health Services</b>		
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
<b>Other Services</b>		
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
<b>Prescription Drug Coverage</b>		
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 prescriptions
Tier 3	0% coinsurance*	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	\$1,700 Person/\$3,400 Family - Aggregate	None
<b>Vision Care</b>		
Adult Vision Care	Not covered	None
Pediatric Vision Care	0% coinsurance*	One eye exam per year to age 21
<b>Other Plan Features</b>		
Gia® Virtual Care	0% coinsurance*	None
Wellness Benefits	\$600 allowance	Get reimbursed up to \$600 per contract, per calendar year
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](http://mvphealthcare.com).

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