

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



Plan Cost-Sharing Highlights	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 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	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	None
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)	\$25 copay	30 combined PT/OT/ST visits per year.
Diagnostic Laboratory Services	\$50 copay	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	20% 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. Includes Diabetic Supplies and Equipment
Prescription Drug Deductible	Rx Brand - \$250 individual / \$500 family	None
Prescription Out-of-Pocket Maximum	\$500 Person/\$1,000 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
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**