Vermont
Plan Name: MVP VT Silver 4 HDHP
Plan Form: FRVT-HMOH-SS-004-S (2026)
Plan Status: Active

Plan Cost-Sharing Highlights	Coverage Information	Limits and Exclusions
Annual Deductible per Contract Year	$2,300 Person/$4,600 Family - Aggregate	None
Co-insurance	35% Person/35% Family	None
Annual Out-of-Pocket Maximum	$7,250 Person/$14,500 Family (Max $10,600 per family member) - Aggregate	None
Primary Care Physician Office Visits	10% coinsurance*	None
Specialist Office Visits	35% coinsurance*	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: 10% coinsurance*/Spec: 35% coinsurance*	None
Diagnostic X-ray	PCP: 10% coinsurance*/Spec: 35% coinsurance*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: 35% coinsurance*/Free-Stnd: 35% coinsurance*	Prior authorization is required for some services
Rehabilitative Services (PT/OT/ST)	35% coinsurance*	30 combined PT/OT/ST visits per year. Speech/Occupational Therapy follows Specialist cost share
Allergy Services	35% coinsurance*	None
Chemotherapy Visit	35% coinsurance*	None
Inpatient Services - Hospital		
Medical/Surgical Admissions	35% coinsurance*	Prior authorization is required for some services
Surgical Services	35% coinsurance*	Prior authorization is required for some services
Inpatient Physical Rehabilitation	35% coinsurance*	None
Outpatient Hospital Services		
Hospital Rehab Services (OT/ST)	35% coinsurance*	30 combined PT/OT/ST visits per year
Hospital Rehab Services (PT)	35% coinsurance*	30 combined PT/OT/ST visits per year
Diagnostic Laboratory Services	35% coinsurance*	None
Diagnostic X-ray	35% coinsurance*	None
Advanced Imaging Services (CT/PET, scans, MRIs)	35% coinsurance*	Prior authorization is required for some services
Ambulatory/Outpatient Surgery	35% coinsurance*	Prior authorization is required for some services
Emergency Care		
Emergency Room (ER) Visit	35% coinsurance*	None
Urgent Care Centers	35% coinsurance*	None
Ambulance (Emergency Medical Transportation)	35% coinsurance*	None
Maternity Services		
Maternity – Prenatal Care	10% coinsurance*	None
Maternity – Physician Delivery	35% coinsurance*	None
Maternity – Inpatient Hospital Services	35% coinsurance*	None

***Deductible applies to this benefit**

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	Coverage Information	Limits and Exclusions
Behavioral Health Services		
Mental Health Inpatient Hospital	35% coinsurance*	None
Mental Health Outpatient	10% coinsurance*	None
Substance Use Disorder Inpatient Hospital	35% coinsurance*	None
Substance Use Disorder Outpatient	10% coinsurance*	None
Residential Treatment	35% coinsurance*	None
Other Services		
Physician Administered Drugs	35% coinsurance*	None
Skilled Nursing Facility	35% coinsurance*	None
Home Health Care	35% coinsurance*	None
Hospice	35% coinsurance*	None
Durable Medical Equipment	35% coinsurance*	Prior authorization is required for some items
Diabetic Supplies & Equipment	50% coinsurance*	Prior authorization is required for some items
Chiropractic Benefit	35% coinsurance*	No visit limit for Chiropractic Care
Acupuncture	Not covered	None
Prescription Drug Coverage		
Tier 1	30 day supply: $10 copay*/90 day supply: $25 copay*	Preventive drugs deductible waived
Tier 2	30 day supply: $40 copay*/90 day supply: $100 copay*	Preventive drugs deductible waived. Prior authorization is required for some prescriptions
Tier 3	50% coinsurance*	Preventive drugs 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
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	0% coinsurance*	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**