Vermont
Plan Name: MVP VT Plus Gold 3 HDHP
Plan Form: FRVT-HMOH-G-003-N
Plan Status: Active

	Coverage Information	Limits and Exclusions
Plan Cost-Sharing Highlights		
Annual Deductible per Contract Year	$3,300 Person/$6,600 Family - Aggregate	None
Co-insurance	As Noted Below	None
Annual Out-of-Pocket Maximum	$3,300 Person/$6,600 Family - Aggregate	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	Covered in Full not subject to Deductible For a full list of covered preventive care services, visit mvphealthcare.com.	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
Adult Annual Physical (One per Contract Year)		
Mammography		
Annual Pap Test & Ob/Gyn Exam		
Immunizations for Adults		
Colonoscopy /Sigmoidoscopy Screening		
Bone Density Tests		
Physician Office Visits		
Diagnostic Laboratory Services	PCP: Covered in Full*/Spec: Covered in Full*	None
Diagnostic X-ray	PCP: Covered in Full*/Spec: Covered in Full*	None
Advanced Imaging Services (CT/PET scans, MRIs)	Spec: Covered in Full*/Free-Stnd: Covered in Full*	Prior authorization is required for some services
Rehabilitative Services (PT/OT/ST)	Covered in Full*	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	Covered in Full*	Prior authorization is required for some services
Surgical Services	Covered in Full*	Prior authorization is required for some services
Inpatient Physical Rehabilitation	Covered in Full*	None
Outpatient Hospital Services		
Hospital Rehabilitation Services (PT/OT/ST)	Covered in Full*	30 combined PT/OT/ST visits per year
Diagnostic Laboratory Services ++	Covered in Full*	None
Diagnostic X-ray ++	Covered in Full*	None
Advanced Imaging Services (CT/PET, scans, MRIs) ++	Covered in Full*	Prior authorization is required for some services
Ambulatory/Outpatient Surgery ++	Covered in Full*	Prior authorization is required for some services
Infusion Therapy	Covered in Full*	None
Emergency Care		
Emergency Room (ER) Visit	Covered in Full*	None
Urgent Care Centers	Covered in Full*	None
Ambulance (Emergency Medical Transportation)	Covered in Full*	None
Maternity Services		
Maternity – Prenatal Care Office Visit	Covered in Full*	None
Maternity – Physician Delivery	Covered in Full*	None
Maternity – Inpatient Hospital Services	Covered in Full*	None
Behavioral Health Services		
Mental Health Inpatient Hospital	Covered in Full*	None
Mental Health Outpatient	Covered in Full*	None
Substance Use Disorder Inpatient Hospital	Covered in Full*	None
Substance Use Disorder Outpatient	Covered in Full*	None
Autism Treatment	Covered in Full*	None

*Deductible applies to this benefit

Vermont
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	Coverage Information	Limits and Exclusions
Assistive Communication Devices for Autism Spectrum Disorder	Covered in Full*	None
Other Services		
Physician Administered Drugs Outpatient	Covered in Full*	None
Skilled Nursing Facility	Covered in Full*	None
Home Health Care	Covered in Full*	None
Hospice	Inpt: Covered in Full*/Outpt: Covered in Full*	None
Durable Medical Equipment	Covered in Full*	None
Diabetic Supplies & Equipment	Covered in Full*	Prior authorization is required for some items
Chiropractic Benefit	Covered in Full*	No visit limit for Chiropractic Care
Acupuncture	$500 Allowance*	None
Home Infusion	Covered in Full*	None
Prescription Drug Coverage		
Annual Pharmacy Out-of-Pocket Maximum	$1,750 Person/$3,500 Family	None
Tier 1	30 day supply: Covered in Full* /90 day supply: Covered in Full*	Preventive drugs 30 day supply $10 copay/prescription; 90 day supply $25 copay/prescription; deductible waived
Tier 2	30 day supply: Covered in Full* /90 day supply: Covered in Full*	Preventive drugs 30 day supply $15 copay/prescription; 90 day supply $37.50 copay/prescription; deductible waived. Prior authorization is required for some prescriptions
Tier 3	30 day supply: Covered in Full* /90 day supply: Covered in Full*	Preventive drugs 30 day/90 supply 5% coinsurance deductible waived. Prior authorization is required for some prescriptions. Includes Diabetic Supplies and Equipment
Ancillary Care		
Adult Vision Care	Not covered	None
Pediatric Vision Care	Covered in Full*	One eye exam per year to age 21
Pediatric Dental	Covered in Full*	Two dental exams per year to age 21. Adult Dental not covered
Other Plan Features		
Gia® Virtual Care	Covered in Full*	None
Wellness Benefits	Get reimbursed up to $600 per contract, per calendar year for expenses associated with activities, tools, and apps that enhance your overall well-being with MVP's Well-Being Reimbursement	
Doula Program	Get reimbursed up to $1,500 per plan year for doula expenses with MVP's Doula Reimbursement Program.	
Plan Highlights	Visit **mvphealthcare.com** for more information. View a complete Glossary of Terms and Member FAQs to better understand your MVP plan benefits.	

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 are available in all states and counties.

***Deductible applies to this benefit**