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

	Coverage Information	Limits and Exclusions
Plan Cost-Sharing Highlights		
Annual Deductible per Contract Year	$2,500 Person/$5,000 Family - Aggregate	None
Co-insurance	35% coinsurance*	None
Annual Out-of-Pocket Maximum	$7,500 Person/$15,000 Family ($12,000 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	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: 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 Rehabilitation Services (PT/OT/ST)	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
Infusion Therapy	35% coinsurance*	None
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 Office Visit	10% coinsurance*	None
Maternity – Physician Delivery	35% coinsurance*	None
Maternity – Inpatient Hospital Services	35% coinsurance*	None
Behavioral Health Services		
Mental Health Inpatient Hospital	35% coinsurance*	None
Mental Health Outpatient	10% coinsurance*	None
Substance Use Disorder Inpatient Hospital	35% coinsurance*	None

*Deductible applies to this benefit

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	Coverage Information	Limits and Exclusions
Substance Use Disorder Outpatient	10% coinsurance*	None
Autism Treatment	35% coinsurance*	None
Assistive Communication Devices for Autism Spectrum Disorder	35% coinsurance*	None
Other Services		
Physician Administered Drugs Outpatient	35% coinsurance*	None
Skilled Nursing Facility	35% coinsurance*	None
Home Health Care	35% coinsurance*	None
Hospice	Inpt: 35% coinsurance*/Outpt: 35% coinsurance*	None
Durable Medical Equipment	35% coinsurance*	None
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
Home Infusion	35% coinsurance*	None
Prescription Drug Coverage		
Annual Pharmacy Out-of-Pocket Maximum	$1,750 Person/$3,500 Family	None
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	30 day supply: 50% coinsurance* /90 day supply: 50% coinsurance*	Preventive drugs 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	$20 copay*	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	Not covered	None
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**