

# Vermont Small Group 2021 Plans

Open enrollment begins on November 1, 2020 for coverage starting January 1, 2021.



	Platinum		Gold			Reflective Silver (only available directly through MVP)				Bronze					
	1	1	2	3	3 HDHP	1	2 HDHP	3	4 HDHP	1	2	3 HDHP	4	5	
	Standard MVP VT	Standard MVP VT	Non-Standard MVP VT Plus		3 HDHP	Non-Standard MVP VT Plus		Standard MVP VT	4 HDHP	Non-Standard MVP VT Plus	2	Standard MVP VT	4	Non-Standard MVP VT Plus	
<b>Plan Deductible</b>															
<b>Individual/Family</b>	\$350/\$700 EMB	\$1,100/\$2,200 EMB	\$700/\$1,400 EMB	\$3,000/\$6,000 AGG		\$1,500/\$3,000 EMB	\$5,100/\$10,200 EMB	\$3,200/\$6,400 EMB	\$1,750/\$3,500 AGG		\$7,250/\$14,500 EMB	\$6,250/\$12,500 EMB	\$5,500/\$11,000 AGG	\$8,400/\$16,800 EMB	\$7,850/\$15,700 EMB
<b>Out-of-Pocket Maximum</b>															
<b>Individual/Family</b>	\$1,400/\$2,800 EMB	\$5,200/\$10,400 EMB	\$6,500/\$13,000 EMB	\$3,000/\$6,000 AGG		\$6,700/\$13,400 EMB	\$5,100/\$10,200 EMB	\$8,150/\$16,300 EMB	\$6,900/\$13,800 <sup>‡</sup> AGG		\$8,400/\$16,800 EMB	\$8,400/\$16,800 EMB	\$6,900/\$13,800 <sup>‡</sup> AGG	\$8,400/\$16,800 EMB	\$7,850/\$15,700 EMB
<b>Medical</b>	<b>New for 2021!</b> \$0 telemedicine services for all emergency, urgent and primary care, as well as nutrition, mental health and psychiatry.*														
<b>Telemedicine*</b>															
<b>Primary Care / Specialist Visit</b>	\$15 NoDD/\$40 NoDD	\$20 NoDD/\$50 NoDD	\$20 NoDD/\$40 NoDD	0%/0%		3 PCP visits per person NoDD then \$30/\$60	0%/0%	\$35 NoDD/\$80 NoDD	10%/30%		\$40/\$100	\$35/\$90	50%/50%	\$40 NoDD/\$100 NoDD	3 PCP visits per person NoDD then 0%/0%
<b>Hospital Facility Inpatient/Outpatient</b>	10%/10%	30%/30%	20%/20%	0%/0%		50%/1,400	0%/0%	50%/50%	30%/30%		50%/50%	50%/50%	50%/50%	0%/0%	0%/0%
<b>Urgent Care / Emergency Room</b>	\$50 co-pay NoDD/\$100	\$60 NoDD/\$150	\$30 NoDD/\$250	0%/0%		\$60/\$400	0%/0%	\$90 NoDD/\$250	30%/30%		\$100/50%	\$100/50%	50%/50%	0%/0%	0%/0%
<b>Diagnostic Radiology / Laboratory Outpatient</b>	10%/10%	30%/30%	\$80/\$40	0%/0%		\$150/\$60	0%/0%	50%/50%	30%/30%		50%/50%	50%/50%	50%/50%	0%/0%	0%/0%
<b>Diabetic Supplies**</b>	50% NoDD	50%	50%	0%		50%	0%	50%	50%		60%	60%	60%	0%	0%
<b>Chiropractic Benefit</b>	\$20 NoDD	\$30 NoDD	\$25 NoDD	0%		\$45	0%	\$45 NoDD	30%		\$50	\$45	50%	\$50 NoDD	0%
<b>Pharmacy</b>															
<b>Prescription Deductible Individual/Family</b>	None	\$100/\$200 Brand Ded	\$250/\$500 Brand Ded	Integrated w/Medical		\$500/\$1,000	Integrated w/Medical	\$350/\$700 Brand Ded	Integrated w/Medical		\$700/\$1,400	\$1,000/\$2,000 Brand Ded	Integrated w/Medical	Integrated w/Medical	Integrated w/Medical
<b>Prescription Out-of-Pocket-Max Individual/Family</b>	\$1,400/\$2,800 EMB	\$1,400/\$2,800 EMB	\$1,400/\$2,800 EMB	Integrated w/Medical \$1,400/\$2,800 AGG		\$1,400/\$2,800 EMB	Integrated w/Medical \$1,400/\$2,800 AGG	Integrated w/Medical \$1,400/\$2,800 EMB	Integrated w/Medical \$1,400/\$2,800 AGG		Integrated w/Medical	Integrated w/Medical \$1,400/\$2,800 EMB	Integrated w/Medical \$1,400/\$2,800 AGG	Integrated w/Medical	Integrated w/Medical
<b>Prescription Cost Share Tier 1 / Tier 2 / Tier 3</b>	\$10 NoDD/\$50 NoDD/50% NoDD	\$12 NoDD/\$55/50%	\$15 NoDD/\$40/50% VBID: \$1	Preventive Drugs \$10/\$15/5% NoDD All other drugs \$0/\$0/0%		\$5/50%/50% VBID: \$1	0%/0%/0% Preventive Drugs NoDD	\$15 NoDD/\$60/50%	\$10/\$40/50% Preventive Drugs No DD		\$25 NoDD/\$100/60% VBID: \$3	\$15 NoDD/\$85/60%	\$12/40%/60% Preventive Drugs NoDD	\$30 NoDD/0%/0%	\$35 NoDD/0%/0% VBID: \$3
<b>Pediatric Dental</b>															
<b>Diagnostic &amp; Preventive</b>	Covered in full NoDD	Covered in full NoDD	Covered in full NoDD	0%		Covered in full NoDD	0%	Covered in full NoDD	0%		Covered in full NoDD	Covered in full NoDD	\$0	Covered in Full NoDD	Covered in Full NoDD
<b>Basic Restorative/Orthodontia &amp; Major Restorative</b>	30%/50%	30%/50%	30%/50%	0%/0%		30%/50%	0%/0%	30%/50%	30%/50%		30%/50%	30%/50%	30%/50%	0%/0%	0%/0%

Amounts listed above are the co-pay or co-insurance after the deductible is met, unless otherwise noted (NoDD). NoDD: Not subject to deductible

## Rates (Effective January 1, 2021–December 31, 2021)

<b>Single</b>	\$798.23	\$673.78	\$699.13	\$682.62	\$574.15	\$585.06	\$589.88	\$577.81	\$491.30	\$497.28	\$502.90	\$521.66	\$508.70
<b>Single + Spouse</b>	\$1,596.46	\$1,347.56	\$1,398.26	\$1,365.24	\$1,148.30	\$1,170.12	\$1,179.76	\$1,155.62	\$982.60	\$994.56	\$1,005.80	\$1,043.32	\$1,017.40
<b>Single + Child(ren)</b>	\$1,540.58	\$1,300.40	\$1,349.32	\$1,317.46	\$1,108.11	\$1,129.17	\$1,138.47	\$1,115.17	\$948.21	\$959.75	\$970.60	\$1,006.80	\$981.79
<b>Single + Spouse + Child(ren)</b>	\$2,243.03	\$1,893.32	\$1,964.56	\$1,918.16	\$1,613.36	\$1,644.02	\$1,657.56	\$1,623.65	\$1,380.55	\$1,397.36	\$1,413.15	\$1,465.86	\$1,429.45

All plans include dependent care coverage until the end of the year that the dependent turns 26. NOTE: Benefits shown in red represent a change from the 2020 plan.

**Questions? We're here to help!** Call 1-844-865-0250 or visit [mvphealthcare.com/vermont](http://mvphealthcare.com/vermont)

**VBID:** Value-Based Insurance Design Maintenance Medications not subject to the deductible.

<sup>‡</sup> This plan features an aggregate deductible and out-of-pocket maximum (OOPM). Each member on a family plan will pay toward the family OOPM. No individual will pay more than the government mandated OOPM of \$8,550. The term Embedded is used on Vermont Health Connect (VHC) materials to define this deductible and OOPM structure.

\* Telemedicine services from MVP Health Care are powered by AmWell and UCM Digital Health. Regulatory restrictions may apply.

\*\*The cost share for diabetic supplies is subject to the pharmacy deductible and the medical out-of-pocket maximum.

These plan overviews are intended to provide a general outline of coverage. In the event of any conflict between this document and your Certificate of Coverage, Summary of Benefits and Coverage, and any applicable Rider(s), your Certificate of Coverage, Summary of Benefits and Coverage, and Rider(s) will be controlling.

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 available in all states and counties.

**Aggregate (AGG):** For any policy with two or more members, the family deductible must be met by any one or any combination of members before the plan will make payments.

**Embedded (EMB):** Each member pays toward, but never exceeds, their individual deductible and/or OOPM until the larger family deductible and/or OOPM is met, after which, the plan makes payments for all members on the contract. The term Stacked is used on VHC materials to define this deductible and/or OOPM structure.

### WellBeing Rewards

Earn up to \$600 per contract, per calendar year, with WellBeing Rewards on MVP VT Plus Non-Standard plans.

**Plans Offered in 2020**

Benefits	Current 2020 Dual Offering 1		Current 2020 Dual Offering 2	
	Standard - Platinum	In-Network Only	Non-Standard - Gold 3 HDHP	In-Network Only
<u>Dr. Office or Virtual Visit</u>				
Primary Care Physician/OBGYN	\$15 copay		0% after deductible	
Specialists	\$40 copay		0% after deductible	
Chiropractic Care	\$20 copay		0% after deductible	
Preventative Care	Covered in full		Covered in full	
Telemedicine via AmWell / UCM Digital Health				
<u>Other Services</u>				
X-Ray / Lab	10% after deductible		0% after deductible	
Outpatient Procedures	10% after deductible		0% after deductible	
Inpatient Care	10% after deductible		0% after deductible	
Emergency Room	\$100 copay after deductible		0% after deductible	
Ambulance	\$60 copay		0% after deductible	
Urgent Care	\$50 copay		0% after deductible	
<u>Retail Prescription Drugs</u>				
Rx Deductible	Deductible waived		Medical deductible applies	
Generic	\$10 copay		0% after deductible	
Preferred Brand	\$50 copay		Preventive Rx:	
Non-Preferred Brand	50% coinsurance		\$5/40%/60% before deductible	
Rx Out of Pocket Maximum	\$1,350 / \$2,700		\$1,400/ \$2,800	
Rx OOPM Integrated with Medical OOPM	No		Yes	
<u>Annual Deductible</u>	<u>Stacked Deductible</u>		<u>Collective Deductible*</u>	
Individual	\$350		\$2,700	
Family	\$700		\$5,400	
<u>Out-of-Pocket Maximum</u>				
Individual	\$1,350		\$2,700	
Family	\$2,700		\$5,400	

\*Integrated Deductible

\*\*Individual within a Family plan OOPM is \$8,550

Enrollment	Standard Platinum Plan		Non-Standard - Gold 3 HDHP	
	2020 MVP Rates		2020 MVP Rates	
Single:	2	\$784.52	4	\$651.82
Couple:	3	\$1,569.04	0	\$1,303.64
Parent & Child(ren):	0	\$1,514.12	0	\$1,258.01
Family:	4	\$2,204.50	0	\$1,831.61

**Total Annual Gross Premium**

**Percentage Increase from Current**

**2020 ER Cost**

**ER HRA - Single \$800**

**ER HRA - 2P/Family \$1,600**

**ER HSA - Single \$500**

**ER HSA - 2P/Family \$1,000**

*employee out of pocket max \$1400 Indv. / \$2800 fam.*

**Total Annual Gross Premium - All Employees**

**Percentage Increase from Current - All Employees**

\$3,200

\$0

\$2,000

\$0

**\$217,617**

**Plans Offered in 2021**

Benefits	Standard - Platinum	HSA Compatible Plan Non-Standard - Gold 3 HDHP	HSA Compatible Plan Non-Standard - Reflective Silver 2 - HDHP
	In-Network Only	In-Network Only	In-Network Only
<b>Dr. Office or Virtual Visit</b>			
Primary Care Physician/OBGYN	\$15 copay	0% after deductible	0% after deductible
Specialists	\$40 copay	0% after deductible	0% after deductible
Chiropractic Care	\$20 copay	0% after deductible	0% after deductible
Preventative Care	Covered in full	Covered in full	Covered in full
Telemedicine via AmWell / UCM Digital Health		Covered in full	Covered in full
<b>Other Services</b>			
X-Ray / Lab	10% after deductible	0% after deductible	0% after deductible
Outpatient Procedures	10% after deductible	0% after deductible	0% after deductible
Inpatient Care	10% after deductible	0% after deductible	0% after deductible
Emergency Room	\$100 copay after deductible	0% after deductible	0% after deductible
Ambulance	\$60 copay	0% after deductible	0% after deductible
Urgent Care	\$50 copay	0% after deductible	0% after deductible
<b>Retail Prescription Drugs</b>			
Rx Deductible (single / family)	Deductible waived	Medical deductible applies	Medical deductible applies
Generic	\$10 copay	0% after deductible	0% after deductible
Preferred Brand	\$50 copay	Preventive Rx: \$10/\$15/5%, , not subject to deductible	
Non-Preferred Brand	50% coinsurance		
Rx Out of Pocket Maximum	\$1,400/ \$2,800	\$1,400/ \$2,800	\$1,400/ \$2,800
Rx OOPM Integrated with Medical OOPM	No	Yes	Yes
<b>Annual Deductible</b>	<b>Stacked Deductible</b>	<b>Collective Deductible*</b>	<b>Stacked Deductible</b>
Individual	\$350	\$3,000	\$5,100
Family	\$700	\$6,000	\$10,200
<b>Out-of-Pocket Maximum</b>			
Individual	\$1,400	\$3,000	\$5,100
Family	\$2,800	\$6,000	\$10,200

\*Integrated Deductible

\*\*Individual within a Family plan OOPM is \$8,550

# Financial Structure for Health Care Plans Offered in 2021

## PLATINUM

Platinum	Premiums Per Month Per Plan	Premiums Per Year Per Plan
Single:	798.23	9,578.76
Couple:	1,596.46	19,157.52
Parent & Child(ren):	1,540.58	18,486.96
Family:	2,243.03	26,916.36

### Total Cost To Town

Employees on each plan	Total Annual Cost
6	57,472.56
3	57,472.56
0	0.00
4	107,665.44
<b>Total Cost To Town</b>	<b>222,610.56</b>
	<b>2.29%</b>

Platinum Out of Pocket Max		
	Medical	Prescription
Single OOP Max	1,400.00	1,400.00
C, P&C, Fam OOP Max	2,800.00	2,800.00

## GOLD 3 HDHP

Gold Out of Pocket Max	
	Medical and Prescription
Single OOP Max	3,000.00
C, P&C, Fam OOP Max	6,000.00

Gold	Premiums Per Month Per Plan	Premiums Per Year Per Plan	Annual H.S.A.	Total cost to Town	Employee Out of pocket max After Town Funded H.S.A.	Cost Difference to Town vs. Platinum
Single:	682.62	8,191.44	1,387.32	9,578.76	1,612.68	0.00
Couple:	1,365.24	16,382.88	2,774.64	19,157.52	3,225.36	0.00
Parent & Child(ren):	1,317.46	15,809.52	2,677.44	18,486.96	3,322.56	0.00
Family:	1,918.16	23,017.92	3,898.44	26,916.36	2,101.56	0.00

## REFLECTIVE SILVER 2 HDHP

Silver Out of Pocket Max	
	Medical and Prescription
Single OOP Max	5,100.00
C, P&C, Fam OOP Max	10,200.00

Silver	Premiums Per Month Per Plan	Premiums Per Year Per Plan	Annual H.S.A.	Total cost to Town	Employee Out of pocket max After Town Funded H.S.A.	Cost Difference to Town vs. Platinum
Single:	585.06	7,020.72	2,558.04	9,578.76	2,541.96	0.00
Couple:	1,170.12	14,041.44	5,116.08	19,157.52	5,083.92	0.00
Parent & Child(ren):	1,129.17	13,550.04	4,936.92	18,486.96	5,263.08	0.00
Family:	1,644.02	19,728.24	7,188.12	26,916.36	3,011.88	0.00