New York Individual Marketplace 2027 Premier® & Premier Plus® Plans

SYRACUSE REGION Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga, and Tompkins Counties

MVP® HEALTH CARE

See other side for New York Individual Direct plans.

MVP Premier Plus Plans (Non-Standard):

Non-Standard plans contain unique features that enhance the value of the benchmark benefits.

MVP Premier Plans (Standard):

Standard plans are based on what the state dictates must be included in benefit details.

	GOLD		SILVER		BRONZE		PLATINUM	GOLD	SILVER	BRONZE	MVP SECURE
	1	2 QHDHP	3 QHDHP	13	2	3 QHDHP	1	1	1	2	1
Plan Deductible[1] Individual/Family	$1,200/$2,400	$1,850/$3,700 AGG	$3,200/$6,400 AGG	$3,350/$6,700	$6,400/$12,800	$6,150/$12,300	$0/$0	$1,200/$2,400	$3,750/$7,500	$5,025/$10,050	$12,000/$24,000
Out-of-Pocket Maximum[1] Individual/Family	$5,900/$11,800	$6,900/$13,800	$7,800/$15,600	$9,950/$19,900	$9,500/$19,000	$8,400/$16,800	$4,000/$8,000	$12,000/$24,000	$12,000/$24,000	$12,000/$24,000	$12,000/$24,000
HSA Eligible	No	Yes	Yes	No	Yes	Yes	No	No	No	Yes	Yes
Medical											
Primary Care/Specialist Visit	3 PCP visits at $0 NoDD then $15 NoDD/$50	$5/$25	$30/$60	3 PCP visits at $0 NoDD then $35/$50	3 PCP visits at 0% NoDD then 40%/40%	$30/$50	$15/$35	$25/$40	1 combined visit at $30 NoDD/$65 NoDD[2] then $30/$65	3 combined visits at $50 NoDD/$75 NoDD then $50/$75	3 PCP visits at 0% NoDD then 0%/0%
Hospital Facility Inpatient/Outpatient	$500/$200	$400/$150	$500/$250	$500/$350	40%/40%	30%/$250	$500/$100	$1,000/$100	$1,500/$150	$1,500/$150	0%/0%
Urgent Care/Emergency Room	$50 NoDD/$350 NoDD	$25/$150	$60/$375	$50 NoDD/$300	40% NoDD/40%	$50/$500	$55/$100	$60/$150	$70/$500	$75/$500	0%/0%
Gia® Virtual Care Services	$0 NoDD[3]	$0 NoDD[3]	$0 NoDD[3]	$0 NoDD[3]	0% NoDD[3]	0% NoDD[3]	$0[3]	$0 NoDD[3]	$0 NoDD[3]	$0 NoDD[3]	$0 NoDD[3]
Diagnostic Radiology/Laboratory Outpatient	$50/$50 NoDD	$25/$25	$60/$60	$50/$50 NoDD	40%/40%	$50/$50	$35/$35	$40/$40	$75/$50	$75/$50	0%/0%
Diabetic Supplies/Insulin	$15 NoDD/$0 NoDD	$5/$0 NoDD	$30/$0 NoDD	$35/$0 NoDD	40%/0% NoDD	$30/$0 NoDD	$15/$0	$25/$0 NoDD	$30/$0 NoDD	$50/$0 NoDD	0%/0%
Pediatric Dental and Vision											
Pediatric Dental Class 1/Class 2/Class 3 and Orthodontia Two Dental Exams per Year	$25 NoDD/20%/50%	$25/20%/50%	$25/20%/50%	$25 NoDD/20%/50%	$25 NoDD/20%/50%	$25/20%/50%	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision Annual Exam/Set of Eyewear	$50/50%	$25/50%	$60/50%	$50/50%	40%/40%	$50/50%	$15/10%	$25/20%	$30/30%	$50/50%	0%/0%
Pharmacy											
Prescription Deductible Individual/Family	$100/$200 Brand Name Only	Integrated with Medical	Integrated with Medical	$50/$100 Brand Name Only	Integrated with Medical	Integrated with Medical	$0/$0	$0/$0	$0/$0	Integrated with Medical	Integrated with Medical
Prescription Cost-Share Tier1/Tier2/Tier 3	$10 NoDD/20%/40%	$5/$15/$25 Preventive Drugs NoDD	$10/$45/$90 Preventive Drugs NoDD	$10 NoDD/$20/$65	$5/$60/$80	$10/$45/$90 Preventive Drugs NoDD	$10/$30/$60	$10 NoDD/ $35 NoDD/$70 NoDD	$15 NoDD/ $40 NoDD/$75 NoDD	$10/$35/$70	0%/0%/0%
Premium Monthly Rates Rates effective January 1, 2027–December 31, 2027.											
Single	$1,686.94	$1,647.73	$1,400.61	$1,381.42	$1,052.44	$1,089.64	$2,092.85	$1,680.05	$1,415.77	$1,081.49	$921.32
Single + Spouse	$3,373.88	$3,295.46	$2,801.22	$2,762.84	$2,104.88	$2,179.28	$4,185.70	$3,360.10	$2,831.54	$2,162.98	$1,842.64
Single + Child(ren)	$2,867.80	$2,801.14	$2,381.04	$2,348.41	$1,789.15	$1,852.39	$3,557.85	$2,856.09	$2,406.81	$1,838.53	$1,566.24
Single + Spouse + Child(ren)	$4,807.78	$4,696.03	$3,991.74	$3,937.05	$2,999.45	$3,105.47	$5,964.62	$4,788.14	$4,034.94	$3,082.25	$2,625.76

[1] Unless otherwise noted, all plan deductibles and/or out-of-pocket maximums are embedded.
[2] Visit(s) may be any combination of Primary Care, Specialist, Outpatient Mental Health Care, or Outpatient Substance Use Services.
[3] Gia virtual care services generally start at $0, but a member cost-share may apply for specialty providers, in-person visits, and referrals. Refer to Gia for estimated costs at the time of service. Eligibility, covered services, and age limits may apply. For serious or life-threatening emergencies call 911.

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These plan overviews are intended to provide a general outline of coverage. For comprehensive benefit details, please review your Certificate of Coverage (COC), Schedule of Benefits, Summary of Benefits and Coverage (SBC), and any applicable Rider(s). Your COC, SBC, and Rider(s) will be controlling. These documents can be found in your MVP online account, or are available by request. For details, call 1-800-TALK-MVP (1-800-825-5687).

Aggregate vs. Embedded

Aggregate (AGG): For a family plan with an aggregate deductible, all individuals on the plan pay together toward one deductible amount before the plan will make payments.

Embedded (EMB): For a family plan with an embedded deductible, each member pays their own, individual deductible. Once an individual has met their deductible, no further deductible is required of them for that plan year. Other family members continue to pay toward their individual deductibles until the family deductible is met. An embedded out-of-pocket maximum works the same way.

QHDHP: Qualified High Deductible Health Plan. All QHDHPs can be paired with a Health Savings Account.

NoDD: Not subject to deductible (only applies to plans with a deductible)

Health benefit plans are issued and 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.

$600 Well-Being Reimbursement

Included on all MVP NY Individual plans!

Get reimbursed up to $600 per contract, per calendar year for well-being items, programs, and activities.

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	GOLD				SILVER			BRONZE				PLATINUM	GOLD	SILVER	BRONZE
	1	2 QHDHP	4	14	3 QHDHP	12	13	2	3 QHDHP	6 QHDHP	7	1	1	1	2
Cost-share amounts below are the co-pay or co-insurance after the deductible is met, unless noted as not subject to deductible (NoDD). All plans include dependent care coverage until the end of the year the dependent turns 26. **Cost-shares in red** indicate a change from the 2026 plan.															
Plan Deductible[1] Individual/Family	$1,200/$2,400	$1,850/$3,700 AGG	$0/$0	$0/$0	$3,200/$6,400 AGG	$3,500/$7,000	$3,350/$6,700	$6,400/$12,800	$6,150/$12,300	$7,800/$15,600	$10,500/$21,000	$0/$0	$1,200/$2,400	$3,750/$7,500	$5,025/$10,050
Out-of-Pocket Maximum[1] Individual/Family	$5,900/$11,800	$6,900/$13,800	$8,200/$16,400	$9,000/$18,000	$7,800/$15,600	$9,700/$19,400	$9,950/$19,900	$9,500/$19,000	$8,400/$16,800	$7,800/$15,600	$10,500/$21,000	$4,000/$8,000	$12,000/$24,000	$12,000/$24,000	$12,000/$24,000
HSA Eligible	No	Yes	No	No	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No	Yes
Medical															
Primary Care/Specialist Visit	3 PCP visits at $0 NoDD then $15 NoDD/$50	$5/$25	3 PCP visits at $0 then $40/$50	5 PCP visits at $0 then $25/$50	$30/$60	$0 NoDD/$50	3 PCP visits at $0 NoDD then $35/$50	3 PCP visits at 0% NoDD then 40%/40%	$30/$50	$0/$0	3 PCP visits at $0 NoDD then 0%/0%	$15/$35	$25/$40	1 combined visit at $30 NoDD/$65 NoDD[2] then $30/$65	3 combined visits at $50 NoDD/$75 NoDD then $50/$75
Hospital Facility Inpatient/Outpatient	$500/$200	$400/$150	$1,000/$400	$1,200/$200	$500/$250	$1,000/$400	$500/$350	40%/40%	30%/$250	$0/$0	0%/0%	$500/$100	$1,000/$100	$1,500/$150	$1,500/$150
Urgent Care/Emergency Room	$50 NoDD/$350 NoDD	$25/$150	$50/$500	$100/$450	$60/$375	$50 NoDD/$500	$50 NoDD/$300	40% NoDD/40%	$50/$500	$0/$0	0%/0%	$55/$100	$60/$150	$70/$500	$75/$500
Gia® Virtual Care Services	$0 NoDD[3]	$0 NoDD[3]	$0[3]	$0[3]	$0 NoDD[3]	$0 NoDD[3]	$0 NoDD[3]	0% NoDD[3]	0% NoDD[3]	$0 NoDD[3]	0% NoDD[3]	$0[3]	$0 NoDD[3]	$0 NoDD[3]	$0 NoDD[3]
Diagnostic Radiology/Laboratory Outpatient	$50/$50 NoDD	$25/$25	$50/$50	$50/$50	$60/$60	$150/$75 NoDD	$50/$50 NoDD	40%/40%	$50/$50	$0/$0	0%/0%	$35/$35	$40/$40	$75/$50	$75/$50
Diabetic Supplies/Insulin	$15 NoDD/$0 NoDD	$5/$0 NoDD	$40/$0	$25/$0	$30/$0 NoDD	$0 NoDD/$0 NoDD	$35/$0 NoDD	40%/0% NoDD	$30/$0 NoDD	$0/$0 NoDD	0%/0% NoDD	$15/$0	$25/$0 NoDD	$30/$0 NoDD	$50/$0 NoDD
Pediatric Dental and Vision															
Pediatric Dental Class 1/Class 2/Class 3 and Orthodontia Two Dental Exams per Year	$25 NoDD/20%/50%	$25/20%/50%	$25/20%/50%	$25/20%/50%	$25/20%/50%	$25 NoDD/20%/50%	$25 NoDD/20%/50%	$25 NoDD/20%/50%	$25/20%/50%	0%/0%/0%	0% NoDD/0%/0%	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision Annual Exam/Set of Eyewear	$50/50%	$25/50%	$50/50%	$50/50%	$60/50%	$50/50%	$50/50%	40%/40%	$50/50%	$0/0%	0%/0%	$15/10%	$25/20%	$30/30%	$50/50%
Pharmacy															
Prescription Deductible Individual/Family	$100/$200 Brand Name Only	Integrated with Medical	$0/$0	$0/$0	Integrated with Medical	Tier 2 & 3 Integrated with Medical	$50/$100 Brand Name Only	Integrated with Medical	Integrated with Medical	Integrated with Medical	Tier 2 & 3 Integrated with Medical	$0/$0	$0/$0	$0/$0	Integrated with Medical
Prescription Cost Share Tier 1/Tier 2/Tier 3	$10 NoDD/20%/40%	$5/$15/$25 Preventive Drugs NoDD	$10/30%/50%	0%/50%/50%	$10/$45/$90 Preventive Drugs NoDD	$10 NoDD/$45/$90	$10 NoDD/$20/$65	$5/$60/$80	$10/$45/$90 Preventive Drugs NoDD	$0/$0/$0 Preventive Drugs NoDD	$5 NoDD/0%/0%	$10/$30/$60	$10 NoDD/$35 NoDD/$70 NoDD	$15 NoDD/$40 NoDD/$75 NoDD	$10/$35/$70
Premium Monthly Rates Rates effective January 1, 2027–December 31, 2027.															
Single	$1,686.94	$1,647.73	$1,737.03	$1,726.58	$1,400.61	$1,428.27	$1,381.42	$1,052.44	$1,089.64	$1,131.63	$1,045.35	$2,092.85	$1,680.05	$1,415.77	$1,081.49
Single + Spouse	$3,373.88	$3,295.46	$3,474.06	$3,453.16	$2,801.22	$2,856.54	$2,762.84	$2,104.88	$2,179.28	$2,263.26	$2,090.70	$4,185.70	$3,360.10	$2,831.54	$2,162.98
Single + Child(ren)	$2,867.80	$2,801.14	$2,952.95	$2,935.19	$2,381.04	$2,428.06	$2,348.41	$1,789.15	$1,852.39	$1,923.77	$1,777.10	$3,557.85	$2,856.09	$2,406.81	$1,838.53
Single + Spouse + Child(ren)	$4,807.78	$4,696.03	$4,950.54	$4,920.75	$3,991.74	$4,070.57	$3,937.05	$2,999.45	$3,105.47	$3,225.15	$2,979.25	$5,964.62	$4,788.14	$4,034.94	$3,082.25

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