New York Small Group 2026 Plans Quarter 2

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

We're here to help!
Call **1-800-TALK-MVP** (1-800-825-5687) or visit **mvphealthcare.com/plans** and select *Plan Options*, then *Employer-Sponsored*.

MVP HEALTH CARE

See other side for Silver and Bronze plans.

Cost-share amounts below are the co-pay or co-insurance after deductible is met, unless otherwise noted as not subject to deductible (NoDD). All plans include dependent care coverage until the end of the month the dependent turns 26. **Cost-shares in red** indicate a change from the 2025 plan.

	Platinum EPO National Network			Platinum HMO Regional Network		Gold EPO National Network								Gold HMO Regional Network				
	1	3	5	2	6	1	2 QHDHP	3	4	6	8	13	14 NEW!	1	2 QHDHP	10	13	14 NEW!
Plan Deductible[1] Individual/Family	$0/$0	$0/$0	$0/$0	$0/$0	$0/$0	$850/$1,700	$1,750/$3,500 AGG	$1,100/$2,200	$0/$0	$350/$700	$4,000/$8,000	$4,000/$8,000	$0/$0	$850/$1,700	$1,750/$3,500 AGG	$900/$1,800	$4,000/$8,000	$0/$0
Out-of-Pocket Maximum[1] Individual/Family	$2,450/$4,900	$2,550/$5,100	$3,550/$7,100	$2,400/$4,800	$2,000/$4,000	$7,000/$14,000	$5,000/$10,000	$5,300/$10,600	$6,750/$13,500	$6,750/$13,500	$8,000/$16,000	$8,000/$16,000	$8,000/$16,000	$7,000/$14,000	$5,000/$10,000	$5,650/$11,300	$8,000/$16,000	$8,000/$16,000
HSA Eligible	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No	Yes	No	No	No
Medical																		
Primary Care/Specialist Visit	3 PCP visits at $0, then $5/$45	3 PCP visits at $0, then $30/$50	3 PCP visits at $0, then $15/$25	3 PCP visits at $0, then $10/$35	3 PCP visits at $0, then $15/$35	3 PCP visits at $0, then $15 NoDD/$50	$10/$20	3 PCP visits at $0 NoDD, then $20/$40	3 PCP visits at $0, then $30/$60	3 PCP visits at $0, then $30 NoDD/$50 NoDD	3 PCP visits at $0, then $40 NoDD/$60 NoDD	$0 NoDD/ $0 NoDD	5 PCP visits at $0, then $25/$50	3 PCP visits at $0, then $15 NoDD/$50	$10/$20	3 PCP visits at $0 NoDD, then $25/$40	$0 NoDD/ $0 NoDD	5 PCP visits at $0, then $25/$50
Hospital Facility Inpatient/Outpatient	$300/$100	$250/$100	$550/$300	$300/$200	$500/$100	$500/$200	$200/$200	$800/$175	$750/$300	$1,000/$300	20%/20%	20%/$1,000	$1,200/$200	$500/$200	$200/$200	$1,000/$150	20%/$1,000	$1,200/$200
Urgent Care/Emergency Room	$45/$100	$50/$150	$25/$200	$35/$200	$35/$100	$50 NoDD/ $300 NoDD	$20/$75	$40/$300	$60/$500	$50 NoDD/ $100 NoDD	$60 NoDD/ $300 NoDD	$0 NoDD/$500	$100/$450	$50 NoDD/ $300 NoDD	$20/$75	$40/$300	$0 NoDD/$500	$100/$450
Gia® Virtual Care Services	$0[2]	$0[2]	$0[2]	$0[2]	$0[2]	$0 NoDD[2]	$0 NoDD[2]	$0 NoDD[2]	$0[2]	$0 NoDD[2]	$0 NoDD[2]	$0 NoDD[2]	$0[2]	$0 NoDD[2]	$0 NoDD[2]	$0 NoDD[2]	$0 NoDD[2]	$0[2]
Diagnostic Radiology/Laboratory Outpatient	$45/$45	$50/$50	$25/$25	$35/$35	$35/$35	$50/$50 NoDD	$20/$20	$40/$40	$60/$60	$50 NoDD/ $50 NoDD	$60 NoDD/ $60 NoDD	$50/$50 NoDD	$50/$50	$50/$50 NoDD	$20/$20	$40/$40	$50/$50 NoDD	$50/$50
Diabetic Supplies/Insulin	$5/$0	$30/$0	$15/$0	$10/$0	$15/$0	$15 NoDD/ $0 NoDD	$10/$0 NoDD	$20/$0 NoDD	$30/$0	$30 NoDD/ $0 NoDD	$40 NoDD/ $0 NoDD	$0 NoDD/ $0 NoDD	$25/$0	$15 NoDD/ $0 NoDD	$10/$0 NoDD	$25/$0 NoDD	$0 NoDD/ $0 NoDD	$25/$0
Pediatric Dental and Vision for Dependents to Age 19																		
Pediatric Dental Class 1/Class 2/Class 3 and Orthodontia Two Dental Exams per Year	$25/20%/50%	$25/20%/50%	$25/20%/50%	$25/20%/50%	$25/20%/50%	$25 NoDD/ 20%/50%	$25/20%/50%	$25 NoDD/ 20%/50%	$25/20%/50%	$25 NoDD/ 20%/50%	$25 NoDD/ 20%/50%	$25 NoDD/ 20%/50%	$25/20%/50%	$25 NoDD/ 20%/50%	$25/20%/50%	$25 NoDD/ 20%/50%	$25 NoDD/ 20%/50%	$25/20%/50%
Pediatric Vision Annual Eye Exam/Set of Eyewear	$45/50%	$50/50%	$25/50%	$35/50%	$35/50%	$50/50%	$20/50%	$40/50%	$60/50%	$50 NoDD/50%	$60 NoDD/50%	$0 NoDD/20%	$50/50%	$50/50%	$20/50%	$40/50%	$0 NoDD/20%	$50/50%
Pharmacy																		
Prescription Deductible Individual/Family	$0/$0	$0/$0	$0/$0	$0/$0	$0/$0	$200/$400 (Brand Name Only)	Integrated with Medical	$0/$0	$0/$0	$0/$0	$0/$0	$250/$500 (Brand Name Only)	$0/$0	$200/$400 (Brand Name Only)	Integrated with Medical	$0/$0	$250/$500 (Brand Name Only)	$0/$0
Prescription Cost-Share Tier1/Tier2/Tier 3	$5/20%/30%	$5/$25/$40	$10/$40/$60	$5/$30/$50	$10/$30/$60	$10 NoDD/ $35/$70	$10/$30/$50 (Preventive Drugs NoDD)	$15 NoDD/ $35 NoDD/ 50% NoDD	$10/30%/50%	$10 NoDD/ 20% NoDD/ 30% NoDD	$10 NoDD/ $40 NoDD/ $60 NoDD	$0 NoDD/ $40/$80	$0/50%/50%	$10 NoDD/ $35/$70	$10/$30/$50 (Preventive Drugs NoDD)	$15 NoDD/ $50 NoDD/ $90 NoDD	$0 NoDD/ $40/$80	$0/50%/50%
Premium Monthly Rates Rates effective April 1, 2026–June 30, 2026.																		
Employee	$1,419.99	$1,420.15	$1,425.10	$1,335.12	$1,339.90	$1,244.31	$1,197.69	$1,215.04	$1,262.44	$1,259.65	$1,191.18	$1,177.40	$1,172.60	$1,162.40	$1,118.84	$1,152.27	$1,099.88	$1,095.40
Employee + Spouse	$2,839.98	$2,840.30	$2,850.20	$2,670.24	$2,679.80	$2,488.62	$2,395.38	$2,430.08	$2,524.88	$2,519.30	$2,382.36	$2,354.80	$2,345.20	$2,324.80	$2,237.68	$2,304.54	$2,199.76	$2,190.80
Employee + Child(ren)	$2,413.98	$2,414.26	$2,422.67	$2,269.70	$2,277.83	$2,115.33	$2,036.07	$2,065.57	$2,146.15	$2,141.41	$2,025.01	$2,001.58	$1,993.42	$1,976.08	$1,902.03	$1,958.86	$1,869.80	$1,862.18
Employee + Spouse + Child(ren)	$4,046.97	$4,047.43	$4,061.54	$3,805.09	$3,818.72	$3,546.28	$3,413.42	$3,462.86	$3,597.95	$3,590.00	$3,394.86	$3,355.59	$3,341.91	$3,312.84	$3,188.69	$3,283.97	$3,134.66	$3,121.89

[1] Unless otherwise noted, all plan deductibles and/or out-of-pocket maximums are embedded.

[2] Gia virtual care services include 24/7 primary and urgent care, nutrition, and some behavioral health services. Beginning January 1, 2026, Gia virtual care services are $0 before the deductible on qualified high-deductible health plans. Some specialty virtual care providers included in Gia, in-person visits, and referrals may be subject to the plan's applicable co-pay/cost-share. Estimated visit costs will be listed in Gia at the time of service.

Aggregate vs. Embedded **Aggregate (AGG) Deductible:** All family plan individuals pay together toward one deductible amount before the plan will make payments. **Embedded (EMB) Deductible:** Each family plan 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.

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QHDHP: Qualified High-Deductible Health Plan **NoDD:** Not subject to deductible

All MVP NY Small Group plans pass for Medicare Creditable Coverage.

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).

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

nystateofhealth The Official Health Plan Marketplace

To learn more about applying for health insurance, including Medicaid, Child Health Plus, Essential Plan, and Qualified Health Plans through NY State of Health, The Official Health Plan Marketplace, visit www.nystateofhealth.ny.gov or call 1-855-355-5777.

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MVP HEALTH CARE

See other side for Platinum and Gold plans.

	Silver EPO National Network					Silver HMO Regional Network			Bronze EPO National Network					Bronze HMO Regional Network		
	2	3 QHDHP	4 HRA[1]	7	8 QHDHP	3 QHDHP	12	13	2	5 QHDHP	6 QHDHP	7 QHDHP	11	2	9 QHDHP	10
Cost-share amounts below are the co-pay or co-insurance after deductible is met, unless otherwise noted as not subject to deductible (NoDD). All plans include dependent care coverage until the end of the month the dependent turns 26. **Cost-shares in red** indicate a change from the 2025 plan.																
Plan Deductible[2] Individual/Family	$4,300/$8,600	$2,700/$5,400 AGG	$2,950/$5,900	$3,100/$6,200	$4,850/$9,700	$2,700/$5,400 AGG	$3,000/$6,000	$3,500/$7,000	$6,150/$12,300	$6,500/$13,000	$7,200/$14,400	$6,350/$12,700	$10,150/$20,300	$6,150/$12,300	$6,250/$12,500	$10,150/$20,300
Out-of-Pocket Maximum[2] Individual/Family	$8,100/$16,200	$7,000/$14,000	$9,300/$18,600	$8,700/$17,400	$7,700/$15,400	$7,000/$14,000	$8,900/$17,800	$9,200/$18,400	$8,900/$17,800	$7,250/$14,500	$7,200/$14,400	$7,250/$14,500	$10,150/$20,300	$8,900/$17,800	$7,250/$14,500	$10,150/$20,300
HSA Eligible	No	Yes	No	No	Yes	Yes	No	No	No	Yes	Yes	Yes	No	No	Yes	No
Medical																
Primary Care/Specialist Visit	3 PCP visits at $0, then $35 NoDD/$60	$25/$50	3 PCP visits at $0 NoDD, then $25/$50	3 PCP visits at $0, then $35 NoDD/$50	$0/$0	$25/$50	3 PCP visits at $0 NoDD, then $30/$50	$0 NoDD/$50	3 PCP visits at $0 NoDD, then $35/$60	$0/50%	0%/0%	40%/40%	3 PCP visits at 0% NoDD, then 0%/0%	3 PCP visits at $0 NoDD, then $35/$60	50%/50%	3 PCP visits at 0% NoDD, then 0%/0%
Hospital Facility Inpatient/Outpatient	30%/$300	$500/$250	$800/$250	$750/$300	$0/$0	$500/$250	$1,500/$375	$1,000/$300	30%/$300	50%/50%	0%/0%	40%/40%	0%/0%	30%/$300	50%/50%	0%/0%
Urgent Care/Emergency Room	$60 NoDD/$350	$50/$300	$50/$300	$50 NoDD/$250	$0/$0	$50/$300	$50/$250	$50 NoDD/$275	$60/$350	50%/$100	0%/0%	40%/40%	0%/0%	$60/$350	50%/50%	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 NoDD[3]	$0 NoDD[3]	$0 NoDD[3]	0% NoDD[3]	0% NoDD[3]	0% NoDD[3]	0% NoDD[3]	$0 NoDD[3]	0% NoDD[3]	0% NoDD[3]
Diagnostic Radiology/Laboratory Outpatient	$60/$60 NoDD	$50/$50	$100/$50	$50/$50 NoDD	$0/$0	$50/$50	$50/$50	$150/$50 NoDD	$60/$60	50%/50%	0%/0%	40%/40%	0%/0%	$60/$60	50%/50%	0%/0%
Diabetic Supplies/Insulin	$35 NoDD/ $0 NoDD	$25/$0 NoDD	$25/$0 NoDD	$35 NoDD/ $0 NoDD	$0/$0 NoDD	$25/$0 NoDD	$30/$0 NoDD	$0 NoDD/ $0 NoDD	$35/$0 NoDD	$0/$0 NoDD	0%/0% NoDD	40%/0% NoDD	0%/0% NoDD	$35/$0 NoDD	50%/0% NoDD	0%/0% NoDD
Pediatric Dental Dependents to Age 19																
Pediatric Dental Class 1/Class 2/Class 3 and Orthodontia Two Dental Exams per Year	$25 NoDD/ 20%/50%	$25/20%/50%	$25 NoDD/ 20%/50%	$25 NoDD/ 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%	$25/20%/50%	0% NoDD/0%/0%	$25 NoDD/ 20%/50%	$25/20%/50%	0% NoDD/0%/0%
Pediatric Vision Annual Eye Exam/Set of Eyewear	$60/50%	$50/50%	$50/50%	$50/50%	$0/$0	$50/50%	$50/50%	$50/50%	$60/50%	50%/50%	0%/0%	40%/40%	0%/0%	$60/50%	50%/50%	0%/0%
Pharmacy																
Prescription Deductible Individual/Family	Integrated with Medical	Integrated with Medical	$0/$0	$0/$0	Integrated with Medical	Integrated with Medical	$0/$0	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical
Prescription Cost-Share Tier1/Tier2/Tier 3	$10/$45/$90	$15/$40/$60 (Preventive Drugs NoDD)	$15 NoDD/ $40 NoDD/ 50% NoDD	$15 NoDD/ 30% NoDD/ 50% NoDD	$20/$50/$75 (Preventive Drugs NoDD)	$15/$40/$60 (Preventive Drugs NoDD)	$10 NoDD/ $35 NoDD/ $70 NoDD	$5 NoDD/ $45/$90	$10/$40/$60	$5/$30/50% (Preventive Drugs NoDD)	0%/0%/0% (Preventive Drugs NoDD)	$10/$40/$60 (Preventive Drugs NoDD)	0% NoDD/0%/0%	$10/$40/$60	$10/$35/$70 (Preventive Drugs NoDD)	0% NoDD/0%/0%
Premium Monthly Rates Rates effective April 1, 2026–June 30, 2026.																
Employee	$1,027.41	$1,050.02	$1,035.24	$1,044.70	$1,020.17	$980.90	$973.31	$976.62	$892.85	$875.51	$946.93	$903.33	$862.16	$834.09	$841.32	$825.51
Employee + Spouse	$2,054.82	$2,100.04	$2,070.48	$2,089.40	$2,040.34	$1,961.80	$1,946.62	$1,953.24	$1,785.70	$1,751.02	$1,893.86	$1,806.66	$1,724.32	$1,668.18	$1,682.64	$1,651.02
Employee + Child(ren)	$1,746.60	$1,785.03	$1,759.91	$1,775.99	$1,734.29	$1,667.53	$1,654.63	$1,660.25	$1,517.85	$1,488.37	$1,609.78	$1,535.66	$1,465.67	$1,417.95	$1,430.24	$1,403.37
Employee + Spouse + Child(ren)	$2,928.12	$2,992.56	$2,950.43	$2,977.40	$2,907.48	$2,795.57	$2,773.93	$2,783.37	$2,544.62	$2,495.20	$2,698.75	$2,574.49	$2,457.16	$2,377.16	$2,397.76	$2,352.70

[1] Silver 4 Health Reimbursement Arrangement (HRA) comes with an Embedded HRA plan and requires a $50 employer contribution.

[2] Unless otherwise noted, all plan deductibles and/or out-of-pocket maximums are embedded.

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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.

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