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

ROCHESTER REGION Livingston, Monroe, Ontario, Seneca, Wayne, and Yates 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
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	$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	$1,282.83	$1,253.02	$1,065.09	$1,050.50	$800.33	$828.62	$1,591.51	$1,277.60	$1,076.62	$822.42	$700.62
Single + Spouse	$2,565.66	$2,506.04	$2,130.18	$2,101.00	$1,600.66	$1,657.24	$3,183.02	$2,555.20	$2,153.24	$1,644.84	$1,401.24
Single + Child(ren)	$2,180.81	$2,130.13	$1,810.65	$1,785.85	$1,360.56	$1,408.65	$2,705.57	$2,171.92	$1,830.25	$1,398.11	$1,191.05
Single + Spouse + Child(ren)	$3,656.07	$3,571.11	$3,035.51	$2,993.93	$2,280.94	$2,361.57	$4,535.80	$3,641.16	$3,068.37	$2,343.90	$1,996.77

[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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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)

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	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[3] 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	$1,282.83	$1,253.02	$1,320.93	$1,312.98	$1,065.09	$1,086.13	$1,050.50	$800.33	$828.62	$860.55	$794.94	$1,591.51	$1,277.60	$1,076.62	$822.42
Single + Spouse	$2,565.66	$2,506.04	$2,641.86	$2,625.96	$2,130.18	$2,172.26	$2,101.00	$1,600.66	$1,657.24	$1,721.10	$1,589.88	$3,183.02	$2,555.20	$2,153.24	$1,644.84
Single + Child(ren)	$2,180.81	$2,130.13	$2,245.58	$2,232.07	$1,810.65	$1,846.42	$1,785.85	$1,360.56	$1,408.65	$1,462.94	$1,351.40	$2,705.57	$2,171.92	$1,830.25	$1,398.11
Single + Spouse + Child(ren)	$3,656.07	$3,571.11	$3,764.65	$3,741.99	$3,035.51	$3,095.47	$2,993.93	$2,280.94	$2,361.57	$2,452.57	$2,265.58	$4,535.80	$3,641.16	$3,068.37	$2,343.90

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