MVP HEALTH PLANS FOR SMALL BUSINESSES

Benefit Choices

MARSHALL STERLING 1/01/2026

Insurance Carrier	MVP	MVP	MVP	MVP	MVP	MVP	MVP
Plan Name	MVP Platinum 1 EPO "Exchange Certified Plan" National Network	MVP Platinum 3 EPO "Exchange Certified Plan" National Network	MVP Platinum 2 HMO "Exchange Certified Plan" Regional Network	MVP Gold 1 EPOc "Exchange Certified Plan" National Network	MVP EPO HDHP Gold 2 (HSA) "Exchange Certified Plan" National Network	MVP Gold 3 EPOc "Exchange Certified Plan" National Network	MVP Gold 4 EPO "Exchange Certified Plan" National Network
Metal Level	Platinum	Platinum	Platinum	Gold	Gold	Gold	Gold
Ded. Type	Embedded	Embedded	Embedded	Embedded	Aggregate/Embedded**	Embedded	Embedded
Plan Type	EPO	EPO	HMO	EPO	EPO HDHP	EPO	EPO
Annual INN Ded. Individual	N/A	N/A	N/A	$850	$1,750	$1,100	N/A
Annual INN Ded. Family	N/A	N/A	N/A	$1,700	$3,500	$2,200	N/A
Coinsurance (In-Network)	N/A (50% DME); 20%(RX in PCP/Specialist Office/OP Facility)	N/A (50% DME); 20%(RX in PCP/Specialist Office/OP Facility)	N/A (50% DME); 20%(RX in PCP/Specialist Office/OP Facility)	N/A (50% after ded. DME); (20% after ded. RX in PCP/Specialist Office/OP Facility)	N/A (50% after ded. DME); (20% after ded. RX in PCP/Specialist Office/OP Facility)	N/A (50% after ded. DME); (20% after ded. RX in PCP/Specialist Office/OP Facility)	N/A (50% DME); 20%(RX in PCP/Specialist Office/OP Facility)
Annual INN OOP Limits	$2,450/$4,900	$2,550/$5,100	$2,400/$4,800	$7,000/$14,000	$5,000/$10,000	$5,300/$10,600	$6,750/$13,500
Annual OON Ded.	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance (Out-of-Network)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Annual OUT OOP Limits	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Primary Care Visit	3 visits at $0, then $5 Copay	3 visits at $0, then $30 Copay	3 visits at $0, then $10 Copay	3 visits at $0, then $15 Copay	$10 Copay after ded.	3 visits at $0, then $20 Copay after ded.	3 visits at $0, then $30 Copay
Specialist Visit	$45 Copay	$50 Copay	$35 Copay	$50 Copay after ded.	$20 Copay after ded.	$40 Copay after ded.	$60 Copay
Inpatient Hospital	$300 Copay	$250 Copay	$300 Copay	$500 Copay after ded.	$200 Copay after ded.	$800 Copay after ded.	$750 Copay
Outpatient Surgery	$100 Copay-OP Hospital $0 Copay-Preferred Facility	$100 Copay-OP Hospital $0 Copay-Preferred Facility	$200 Copay-OP Hospital $0 Copay-Preferred Facility	$200 Copay after ded.-OP Hospital $0 after ded.-Preferred Facility	$200 Copay after ded.-OP Hospital $0 after ded.-Preferred Facility	$175 Copay after ded.-OP Hospital $0 after ded.-Preferred Facility	$300 Copay-OP Hospital $0 Copay-Preferred Facility
Urgent Care	$45 Copay	$50 Copay	$35 Copay	$50 Copay	$20 Copay after ded.	$40 Copay after ded.	$60 Copay
Emergency Room	$100 Copay	$150 Copay	$200 Copay	$300 Copay	$75 Copay after ded.	$300 Copay after ded.	$500 Copay
Outpatient Lab	$5 Copay -PCP $45 Copay-Specialist/OP Hospital $0 Copay-Preferred Facility	$30 Copay-PCP $50 Copay-Specialist/OP Hospital $0 Copay-Preferred Facility	$10 Copay-PCP $35 Copay-Specialist/OP Hospital $0 Copay-Preferred Facility	$15 Copay-PCP $50 Copay-Specialist/OP Hospital $0 Copay-Preferred Facility	$10 Copay after ded.-PCP $20 after ded.-Specialist/OP Hosp. $0 after ded.-Preferred Facility	$20 Copay after ded.-PCP $40 after ded.-Specialist/OP Hosp. $0 after ded.-Preferred Facility	$30 Copay-PCP $60 Copay-Specialist/OP Hospital $0 Copay-Preferred Facility
Outpatient X-Ray	$5 Copay -PCP $45 Copay-Specialist/OP Hospital $0 Copay-Preferred Facility	$30 Copay-PCP $50 Copay-Specialist/OP Hospital $0 Copay-Preferred Facility	$10 Copay-PCP $35 Copay-Specialist/OP Hospital $0 Copay-Preferred Facility	$15 Copay-PCP $50 after ded.-Specialist/OP Hosp. $0 after ded.-Preferred Facility	$10 Copay after ded.-PCP $20 after ded.-Specialist/OP Hosp. $0 after ded.-Preferred Facility	$20 Copay after ded.-PCP $40 after ded.-Specialist/OP Hosp. $0 after ded.-Preferred Facility	$30 Copay-PCP $60 Copay-Specialist/OP Hospital $0 Copay-Preferred Facility
Rx Ded.	N/A	N/A	N/A	$200/$400 ded. (Tier 1 Waived)	Integrated ded.	N/A	N/A
Tier 1 / Tier 2 / Tier 3	5/20%/30%	5/25/40	5/30/50	10/35/70	10/30/50	15/35/50%	10/30%/50%
Creditable Coverage	YES	YES	YES	YES	YES	YES	YES
AM Best Rating***	Not Listed	Not Listed	Not Listed	Not Listed	Not Listed	Not Listed	Not Listed
RATES							
Single Plan Rate	$1,370.60	$1,370.76	$1,257.69	$1,201.04	$1,156.04	$1,172.78	$1,218.53
Employee/Spouse Plan Rate	$2,741.20	$2,741.52	$2,515.38	$2,402.08	$2,312.08	$2,345.56	$2,437.06
Employee/Child(ren) Plan Rate	$2,330.02	$2,330.29	$2,138.07	$2,041.77	$1,965.27	$1,993.73	$2,071.50
Family Plan Rate	$3,906.21	$3,906.67	$3,584.42	$3,422.96	$3,294.71	$3,342.42	$3,472.81
Pediatric Dental & Vision	Included in Rates	Included in Rates	Included in Rates	Included in Rates	Included in Rates/Ded. applies to HDHP Plans	Included in Rates	Included in Rates

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Insurance Carrier	MVP	MVP	MVP	MVP	MVP	MVP	MVP
Plan Name	MVP Gold 6 EPOc "Exchange Certified Plan" National Network	MVP Gold 14 EPO "Exchange Certified Plan" National Network INEWI	MVP Gold 14 HMO "Exchange Certified Plan" Regional Network "NEW"	MVP Silver 2 EPOc "Exchange Certified Plan" National Network	MVP EPO HDHP Silver 3 (HSA) "Exchange Certified Plan" National Network	MVP Silver 7 EPOc "Exchange Certified Plan" National Network	MVP HMO HDHP Silver 3 (HSA) "Exchange Certified Plan" Regional Network
Metal Level	Gold	Gold	Gold	Silver	Silver	Silver	Silver
Ded. Type	Embedded	Embedded	Embedded	Embedded	Aggregate/Embedded**	Embedded	Aggregate/Embedded**
Plan Type	EPO	EPO	HMO	EPO	EPO HDHP	EPO	HMO HDHP
Annual INN Ded. Individual	$350	N/A	N/A	$4,300	$2,700	$3,100	$2,700
Annual INN Ded. Family	$700	N/A	N/A	$8,600	$5,400	$6,200	$5,400
Coinsurance (In-Network)	N/A (50% after ded. DME); (20% after ded. RX in PCP/Specialist Office/OP Facility)	N/A (50% DME); (20% after ded. RX in PCP/Specialist Office/OP Facility)	N/A (50% DME); (20% after ded. RX in PCP/Specialist Office/OP Facility)	30% (50% after ded. DME); (20% after ded. RX in PCP/Specialist Office/OP Facility)	N/A (50% after ded. DME); (20% after ded. RX in PCP/Specialist Office/OP Facility)	N/A (50% after ded. DME); (20% after ded. RX in PCP/Specialist Office/OP Facility)	N/A (50% after ded. DME); (20% after ded. RX in PCP/Specialist Office/OP Facility)
Annual INN OOP Limits	$6,750/$13,500	$8,000/$16,000	$8,000/$16,000	$8,100/$16,200	$7,000/$14,000	$8,700/$17,400	$7,000/$14,000
Annual OON Ded.	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance (Out-of-Network)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Annual OUT OOP Limits	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Primary Care Visit	3 visits at $0, then $30 Copay	5 visits at $0, then $25 Copay	5 visits at $0, then $25 Copay	3 visits at $0, then $35 Copay	$25 Copay after ded.	3 visits at $0, then $35 Copay	$25 Copay after ded.
Specialist Visit	$50 Copay	$50 Copay	$50 Copay	$60 Copay after ded.	$50 Copay after ded.	$50 Copay after ded.	$50 Copay after ded.
Inpatient Hospital	$1,000 Copay after ded.	$1,200 Copay	$1,200 Copay	30% after ded.	$500 Copay after ded.	$750 Copay after ded.	$500 Copay after ded.
Outpatient Surgery	$300 Copay after ded.-OP Hospital $0 after ded.-Preferred Facility	$200 Copay	$200 Copay	$300 Copay after ded.-OP Hospital $0 after ded.-Preferred Facility	$250 Copay after ded.-OP Hospital $0 after ded.-Preferred Facility	$300 Copay after ded.-OP Hospital $0 after ded.-Preferred Facility	$250 Copay after ded.-OP Hospital $0 after ded.-Preferred Facility
Urgent Care	$50 Copay	$100 Copay	$100 Copay	$60 Copay	$50 Copay after ded.	$50 Copay	$50 Copay after ded.
Emergency Room	$100 Copay	$450 Copay	$450 Copay	$350 Copay after ded	$300 Copay after ded.	$250 Copay after ded.	$300 Copay after ded.
Outpatient Lab	$30 Copay-PCP $50 Copay-Specialist/OP Hospital $0 Copay-Preferred Facility	$25 Copay-PCP $50 Copay-Specialist/OP Hospital $0 Copay-Preferred Facility	$25 Copay-PCP $50 Copay-Specialist/OP Hospital $0 Copay-Preferred Facility	$35 Copay-PCP $60 Copay-Specialist/OP Hospital $0 Copay-Preferred Facility	$25 Copay after ded.-PCP $50 after ded.-Specialist/OP Hosp. $0 after ded.-Preferred Facility	$35 Copay-PCP $50 Copay-Specialist/OP Hospital $0 Copay-Preferred Facility	$25 Copay after ded.-PCP $50 after ded.-Specialist/OP Hosp. $0 after ded.-Preferred Facility
Outpatient X-Ray	$30 Copay-PCP $50 Copay-Specialist/OP Hospital $0 Copay-Preferred Facility	$25 Copay-PCP $50 Copay-Specialist/OP Hospital $0 Copay-Preferred Facility	$25 Copay-PCP $50 Copay-Specialist/OP Hospital $0 Copay-Preferred Facility	$35 Copay-PCP $60 after ded.Specialist/OP Hosp. $0 after ded.-Preferred Facility	$25 Copay after ded.-PCP $50 after ded.-Specialist/OP Hosp. $0 after ded.-Preferred Facility	$35 Copay-PCP $50 after ded-Specialist/OP Hosp. $0 after ded.-Preferred Facility	$25 Copay after ded.-PCP $50 after ded.-Specialist/OP Hosp. $0 after ded.-Preferred Facility
Rx Ded.	N/A	N/A	N/A	Integrated ded.	Integrated ded.	N/A	Integrated ded.
Tier 1 / Tier 2 / Tier 3	10/20%/30%	0/50%/50%	0/50%/50%	10/45/90	15/40/60	15/30%/50%	15/40/60
Creditable Coverage	YES	YES	YES	YES	YES	YES	YES
AM Best Rating***	Not Listed	Not Listed	Not Listed	Not Listed	Not Listed	Not Listed	Not Listed
RATES							
Single Plan Rate	$1,215.84	$1,131.82	$1,031.87	$991.68	$1,013.50	$1,008.37	$924.01
Employee/Spouse Plan Rate	$2,431.68	$2,263.64	$2,063.74	$1,983.36	$2,027.00	$2,016.74	$1,848.02
Employee/Child(ren) Plan Rate	$2,066.93	$1,924.09	$1,754.18	$1,685.86	$1,722.95	$1,714.23	$1,570.82
Family Plan Rate	$3,465.14	$3,225.69	$2,940.83	$2,826.29	$2,888.48	$2,873.85	$2,633.43
Pediatric Dental & Vision	Included in Rates	Included in Rates	Included in Rates	Included in Rates	Included in Rates/Ded. applies to HDHP Plans	Included in Rates	Included in Rates/Ded. applies to HDHP Plans

MVP HEALTH PLANS FOR SMALL BUSINESSES
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MARSHALL STERLING 1/01/2026

Insurance Carrier	MVP	MVP	MVP	MVP
Plan Name	MVP Bronze 2 EPOc (Not HSA Qualified) "Exchange Certified Plan" National Network	MVP EPO HDHP Bronze 6 (HSA) "Exchange Certified Plan" National Network	MVP EPO HDHP Bronze 7 (HSA) "Exchange Certified Plan" National Network	MVP Bronze 2 HMOc (Not HSA Qualified) "Exchange Certified Plan" Regional Network
Metal Level	Bronze	Bronze	Bronze	Bronze
Ded. Type	Embedded	Embedded	Embedded	Embedded
Plan Type	EPO	EPO HDHP	EPO HDHP	HMO
Annual INN Ded. Individual	$6,150	$7,200	$6,350	$6,150
Annual INN Ded. Family	$12,300	$14,400	$12,700	$12,300
Coinsurance (In-Network)	30% (50% after ded. DME); (20% after ded. RX in PCP/Specialist Office/OP Facility)	N/A (100% after ded. DME & RX in PCP/Specialist Office/OP Facility)	40% (40% after ded. DME & RX in PCP/Specialist Office/OP Facility)	30% (50% after ded. DME); (20% after ded. RX in PCP/Specialist Office/OP Facility)
Annual INN OOP Limits	$8,900/$17,800	$7,200/$14,400	$7,250/$14,500	$8,900/$17,800
Annual OON Ded.	N/A	N/A	N/A	N/A
Coinsurance (Out-of-Network)	N/A	N/A	N/A	N/A
Annual OUT OOP Limits	N/A	N/A	N/A	N/A
Primary Care Visit	3 visits at $0, then $35 Copay after ded.	100% after ded.	40% after ded.	3 visits at $0, then $35 Copay after ded.
Specialist Visit	$60 Copay after ded.	100% after ded.	40% after ded.	$60 Copay after ded.
Inpatient Hospital	30% after ded.	100% after ded.	40% after ded.	30% after ded.
Outpatient Surgery	$300 Copay after ded.-OP Hospital $0 after ded.-Preferred Facility	100% after ded.-OP Hospital/Preferred Facility	40% after ded.-OP Hospital/Preferred Facility	$300 Copay after ded.-OP Hospital $0 after ded.-Preferred Facility
Urgent Care	$60 Copay after ded.	100% after ded.	40% after ded.	$60 Copay after ded.
Emergency Room	$350 Copay after ded.	100% after ded.	40% after ded.	$350 Copay after ded.
Outpatient Lab	$35 Copay after ded.-PCP $60 after ded.-Specialist/OP Hosp. $0 after ded.-Preferred Facility	100% after ded.-PCP/Specialist/OP Hospital/Preferred Facility	40% after ded.-PCP/Specialist/OP Hospital 100% after ded. Preferred Facility	$35 Copay after ded.-PCP $60 after ded.-Specialist/OP Hosp. $0 after ded.-Preferred Facility
Outpatient X-Ray	$35 Copay after ded.-PCP $60 after ded.-Specialist/OP Hosp. $0 after ded.-Preferred Facility	100% after ded.-PCP/Specialist/OP Hospital/Preferred Facility	40% after ded.-PCP/Specialist/OP Hospital 100% after ded. Preferred Facility	$35 Copay after ded.-PCP $60 after ded.-Specialist/OP Hosp. $0 after ded.-Preferred Facility
Rx Ded.	Integrated ded.	Integrated ded.	Integrated ded.	Integrated ded.
Tier 1 / Tier 2 / Tier 3	10/40/60	100%/100%/100%	10/40/60	10/40/60
Creditable Coverage	YES	YES	YES	YES
AM Best Rating***	Not Listed	Not Listed	Not Listed	Not Listed
RATES				
Single Plan Rate	$861.81	$914.00	$871.91	$785.71
Employee/Spouse Plan Rate	$1,723.62	$1,828.00	$1,743.82	$1,571.42
Employee/Child(ren) Plan Rate	$1,465.08	$1,553.80	$1,482.25	$1,335.71
Family Plan Rate	$2,456.16	$2,604.90	$2,484.94	$2,239.27
Pediatric Dental & Vision	Included in Rates	Included in Rates/Ded. applies to HDHP Plans	Included in Rates/Ded. applies to HDHP Plans	Included in Rates