2025 MV Benefit Rate

Ho Ho Kus Inc

Change Date: 01/01/2025

Renewal Date: 02/01/2025 - 01/31/2026

Rates from: 01/01/2025 - 01/31/2026

Basic MV to Base MV			
Employee Only	*Employee+Spouse*	*Employee+Child(ren)*	*Family*
$ 536.76	$ 856.74	$ 805.51	$1,076.92

Plus MV to Premium MV			
Employee Only	*Employee+Spouse*	*Employee+Child(ren)*	*Family*
$ 642.60	$1,062.75	$ 945.03	$1,306.91

Premier MV to Superior MV			
Employee Only	*Employee+Spouse*	*Employee+Child(ren)*	*Family*
$ 664.20	$1,084.55	$ 970.10	$1,362.50

Ultimate MV to Preferred MV			
Employee Only	*Employee+Spouse*	*Employee+Child(ren)*	*Family*
$ 785.07	$1,584.41	$1,356.03	$2,040.08

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MV Plans

Plan Comparison

	Current Plan BASIC MV		Renewal Plan BASE MV	
Deductible (Ind/Fam)	$0		$0	
Out of Pocket Max (Ind/Fam)	$9,450 / $18,900	N/A	$8,700 / $17,400	
Medical Benefits *Services cannot be performed at a hospital*	In Network	Out of Network	In Network	Out of Network
Wellness and Preventive	Covered at 100%		Covered at 100%	
Primary Care Visits	$25 Copay | 8 per year		$25 Copay | 8 per year	
Specialist Visits	$50 Copay | 8 per year		$50 Copay | 8 per year	
Urgent Care Visits	$50 Copay | 2 per year		$50 Copay | 2 per year	
Lab Services & (Radiology RBP)	$50 Copay | 3 per year		$50 Copay | 3 combined per year	
Advanced Imaging RBP*	$350 Copay | 1 per year		$350 Copay | 1 per year	
Radiology & Advanced Imaging	Not Covered		Covered 100% Medmo	
Telemedicine	$0 Copay | Unlimited	N/A	$0 Copay | Unlimited	
Rx Benefits				
Generic / Preferred & Non Preferred	$5 Copay / Not Covered	Not Covered	$10 Copay / Discount Only	
Hospital Services RBP				
Inpatient Hospitalization & Surgery*	$350 Copay | 5 days & 2 Surgeries per year		$350 Copay per admission | 5 days & 2 Surgeries per year	
Outpatient Hospitalization & Surgery*	$350 Copay | 1 per year		$350 Copay | 1 per year	
Emergency Room Services	$350 Copay | 1 per year		$350 Copay | 1 per year	
Other Services *Services cannot be performed at a hospital*				
Chiropractic Services*	$50 Copay | 10 per year	Not Covered	$50 Copay | 10 per year	
Home Health Care*	$25 Copay | 10 per year	Not Covered	$25 Copay | 10 per year	Not Covered
Emergency Ground Transportation RBP	$250 Copay | 1 per year		$250 Copay | 1 per year	
Treatment for Substance Abuse (Inpatient* RBP/Outpatient)	$250 Copay | 5 days per year / $25 Copay | 8 days per year		$250 Copay per admission | 5 per year / $25 Copay | 8 per year	
Cancer Treatment	Not Covered	Not Covered	Not Covered	
Pregnancy Services RBP				
Professional Services	Not Covered		Not Covered	
Inpatient Facility	Not Covered		Not Covered	

* Pre-Authorization Required | RBP Referenced Based Pricing

MV Plans

Plan Comparison

	Current Plan PLUS MV		Renewal Plan PREMIUM MV	
Deductible (Ind/Fam)	$0		$0	
Out of PocketMax (Ind/Fam)	$9,450 / $18,900	N/A	$9,100 / $18,200	
Medical Benefits *Cannot be performed at hospital*	In Network	Out of Network	In Network	Out of Network
Wellness and Preventive	Covered at 100%		Covered at 100%	40% Coinsurance
Primary Care Visits	$15 Copay | 10 per year		$15 Copay	40% Coinsurance
Specialist Visits	$25 Copay | 10 per year		$15 Copay	40% Coinsurance
Urgent Care Visits	$35 Copay | 3 per year		$50 Copay	40% Coinsurance
Lab Services /Radiology (X-ray, Ultrasound)	$50 Copay | 3 per year		$50 Copay	40% Coinsurance
Advanced Imaging RBP*	$350 Copay | 2 per year		$350 Copay | 2 per year	
Radiology & Advanced Imaging	Not Covered		Covered 100% Medmo	
Telemedicine	$0 Copay | Unlimited		$0 Copay | Unlimited	
Rx Benefits				
Preventive/Generic Rx	$0 Copay / $5 Copay	Not Covered	$10 Copay	
Preferred Brand/ Non-Preferred Rx	$40 Copay / $80 Copay	Not Covered	Discount Only	
Hospital Services RBP				
Inpatient Hospitalization & Surgery*	$350 Copay | 7 days & 3 Surgeries per year		$500 Copay | 7 days & 3 Surgeries per year	
Outpatient Hospitalization & Surgery*	$350 Copay | 2 per year		$350 Copay | 1 per year	
Emergency Room Services	$350 Copay | 1 per year		$500 Copay | 1 per year	
Other Services *Cannot be performed at hospital*				
Chiropractic Services*	$25 Copay | 10 per year	Not Covered	$50 Copay | 10 per year	40% Coinsurance
Home Health Care*	$25 Copay | 15 per year	Not Covered	$50 Copay | 10 per year	40% Coinsurance
Emergency Ground Transportation RBP	$250 Copay | 1 per year		$500 Copay | 1 per year	40% Coinsurance
Treatment for Substance Abuse (Inpatient) RBP	$75 Copay | 7 days & 3 Surgeries per year		$500 Copay per admission | 7 per year	
Treatment for Substance Abuse (Outpatient)	$350 Copay | 2 days & 2 Surgeries per year		$75 Copay | 8 per year	40% Coinsurance
Physical,Occupational & Speech Therapy*	Not Covered	Not Covered	$50 Copay | 12 per year	40% Coinsurance
Chemotherapy, Radiation& Dialysis	Not Covered	Not Covered	Not Covered	Not Covered
Pregnancy Services RBP				
Professional Services*	$350 Copayment		$350 Copay	40% Coinsurance
Inpatient Facility*	$350 Copayment per admission		$500 Copayment per admission	

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MV Plans

Plan Comparison

	Current Plan PREMIER MV		Renewal Plan SUPERIOR MV	
Deductible (Ind/Fam)	$0		$0	
Out of PocketMax (Ind/Fam)	$9,450 / $18,900	N/A	$5,000 / $10,000	
Medical Benefits *Cannot be performed at hospital*	In Network	Out of Network	In Network	Out of Network
Wellness and Preventive	Covered at 100%		Covered at 100%	
Primary Care Visits	$15 Copay | 12 per year		$15 Copay | 12 per year	
Specialist Visits	$25 Copay | 12 per year		$25 Copay | 12 per year	
Urgent Care Visits	$35 Copay | 3 per year		$35 Copay | 3 per year	
Lab Services & Radiology	$50 Copay | 4 per year combined		$50 Copay | 4 per year combined	
Advanced Imaging RBP	$350 Copay | 3 per year		$350 Copay | 3 per year	
Radiology & Advanced Imaging	Not Covered		Covered 100% Medmo	
Telemedicine	$0 Copay | Unlimited		$0 Copay | Unlimited	
Rx Benefits				
Preventive/Generic Rx	$0 Copay / $5 Copay	Not Covered	$10 Copay	
Preferred Brand/ Non-Preferred Rx	$40 Copay / $80 Copay	Not Covered	Tier 2: $50 Copay Tier 3: $75 Copay	
Hospital Services RBP				
Inpatient Hospitalization & Surgery*	$350 Copay | 10 days & 4 surgeries per year		$350 Copay | 10 days & 4 surgeries per year	
Outpatient Hospitalization & Surgery	* $350 Copay | 2 per year		$350 Copay | 2 per year	
Emergency Room Services	$350 Copay | 2 per year		$350 Copay | 2 per year	
Other Services *Cannot performed at hospital*				
Chiropractic Services*	$25 Copay | 10 per year	Not Covered	$25 Copay | 10 per year	
Home Health Care*	$25 Copay | 20 per year	Not Covered	$25 Copay | 20 per year	Not Covered
Emergency Ground Transportation RBP	$250 Copay | 2 per year		$250 Copay | 2 per year	
Treatment for Substance Abuse (Inpatient) RBP	$250 Copay | 10 days a year		$250 Copay per admission | 10 days a year	
Treatment for Substance Abuse (Outpatient)	$25 Copay | 12 per year		$25 Copay | 12 per year	
Physical,Occupational & Speech Therapy*	$50 Copay | 6 per year	Not Covered	$50 Copay | 12 per year	Not Covered
Chemotherapy, Radiation & Dialysis	Not Covered	Not Covered	Not Covered	Not Covered
Pregnancy Services RBP				
Professional Services	$350 Copayment		$350 Copayment	
Inpatient Facility	$350 Copayment per admission		$350 Copayment per admission	

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MV Plans

Plan Comparison

	Current Plan ULTIMATE MV		Renewal Plan PREFERRED MV	
Deductible (Ind/Fam)	In Network $0 | Out of Network $500/$1000		In Network $0 | Out of Network $0	
Out of Pocket Max (Ind/Fam)	$6,000 / $12,000	N/A	$9,100 / $18,200	N/A
Medical Benefits *Cannot be performed at hospital*	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Wellness and Preventive	Covered at 100%	After ded. 40% Coinsurance	Covered at 100%	40% Coinsurance
Primary Care Visits	$20 Copay	After ded. 40% Coinsurance	$15 Copay	40% Coinsurance
Specialist Visits	$40 Copay	After ded. 40% Coinsurance	$15 Copay	40% Coinsurance
Urgent Care Visits	$50 Copay	After ded. 40% Coinsurance	$50 Copay	40% Coinsurance
Lab Services & (Radiology RBP)	$50 Copay	After ded. 40% Coinsurance	$50 Copay	40% Coinsurance
Advanced Imaging RBP*	$400 Copay		$350 Copay	40% Coinsurance
Medmo Radiology & Advanced Imaging	-	-	Covered 100% Medmo	
Telemedicine	$0 Copay | Unlimited	N/A	$0 Copay | Unlimited	
Rx Benefits				
Generic Rx	$5 Copay		$10 Copay	
Preferred Brand/Non-Preferred	Tier 2: $40 Copay / Tier 3: $80 Copay		Tier 2: $50 Copay / Tier 3: $75 Copay	
Hospital Services RBP				
Inpatient Hospitalization & Surgery*	$400 Copay		30% Coinsurance	
Outpatient Hospitalization & Surgery*	$400 Copay		30% Coinsurance	
Emergency Room Services	$400 Copay		$500 Copay	
Other Services *Cannot be performed at hospital*				
Chiropractic Services*	$40 Copay | 10 per year	After ded. 40% Coinsurance	$50 Copay | 20 per year	40% Coinsurance
Home Health Care*	$25 Copay | 20 per year	Not Covered	$50 Copay | 20 per year	40% Coinsurance
Emergency Ground Transportation RBP	$400 Copay		$500 Copay	
Treatment for Mental/Nervous Disorder & Chemical Abuse (Inpatient* RBP/Outpatient)	$250 Copay per day / $25 Copay per day		Inpatient (20 per year): $750 Outpatient (25 per year): $75 Copay	40% Coinsurance
ABA, Physical, Occupational & Speech Therapy*	$75 Copay | 10 per year	Not Covered	$50 Copay | 12 per year	40% Coinsurance
Chemotherapy, Radiation & Dialysis (Inpatient/Outpatient) RBP	$400 Copay		30% Coinsurance	30% Coinsurance
Pregnancy Services RBP				
Professional Services*	$50 Copayment	After ded. 40% Coinsurance	$350 Copayment	40% Coinsurance
Inpatient Facility*	$400 Copayment per admission		$500 Copayment per admission	

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