



SUMMARY OF BENEFITS

Conover Advertising

HPHC
HMO

2/1/2023

to

1/31/2024



Swipe card for benefit listed under the "Difference Card Pays" column.



Submit a claim for reimbursement with EOB for payment.

TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	HPHC BENEFIT
PHYSICIAN SERVICES			
Primary Care Office Visit Copay	\$30	Deductible, then \$45	Deductible, then \$75
Specialist Office Visit Copay	\$30	Deductible, then \$120	Deductible, then \$150
Preventive Care / Screening / Immunization	No Charge		
Urgent Care	\$30	Deductible, then \$120	Deductible, then \$150
PHARMACY			
Prescription Deductible Application	Integrated with Medical Deductible		
Prescription Individual Deductible	\$0	Int. with Med Ded	Int. with Med Ded
Prescription Family Deductible	\$0	Int. with Med Ded	Int. with Med Ded
Retail Prescriptions	20%	80%	\$5/ \$30 / 50% to \$125 / 50% to \$250 / 50% to \$500
Mail Order Prescriptions	20%	80%	\$10 / \$60 / 50% to \$250 / 50% to \$750 / 50% to \$1,500
DIAGNOSTIC PROCEDURES			
Diagnostic Test- Lab Bloodwork	\$0	Deductible, then \$75	Deductible, then \$75
Diagnostic Test X-Ray	\$0	Deductible, then \$150	Deductible, then \$150
Complex Imaging (CT/Pet Scans, MRIs)	\$50	Deductible, then \$950	Deductible, then \$1,000
HOSPITAL SERVICES			
Emergency Room Care	\$100	Deductible, then \$1,400	Deductible, then \$1,500
Outpatient Surgery	\$1,000	Deductible	Deductible, then \$1,000
Inpatient Hospital	\$1,000	Deductible, then \$500	Deductible, then \$1,500
IN NETWORK DEDUCTIBLE & COINSURANCE			
Qualified High Deductible Health Plan	No		
Deductible Accumulation Period	Plan Year		
Family Deductible Accumulation Type	Individual Accumulation		
In-Network Individual Deductible	\$0	\$3,600	\$3,600
In-Network Family Deductible	\$0	\$7,200	\$7,200
In-Network Individual Coinsurance Limit	\$0	20% (DME Only)	20% (DME Only)
In-Network Family Coinsurance Limit	\$0	20% (DME Only)	20% (DME Only)
OUT OF NETWORK DEDUCTIBLE & COINSURANCE			
Out-of-Network Individual Deductible	N/A	N/A	N/A
Out-of-Network Family Deductible	N/A	N/A	N/A
Out-of-Network Individual Coinsurance Limit	N/A	N/A	N/A
Out-of-Network Family Coinsurance Limit	N/A	N/A	N/A

In-Network Family Multiplier 2

Out-of-Network Family Multiplier N/A

Mail Order Multiplier 2, 2, 2, 3, 3x

All claims must be submitted within 3 months of the end of the deductible accumulation period.
Terminated members must submit claims within 3 months of the termination date.
Information on this document based on carrier SBC.



Please have your provider swipe the Difference Card for the following amounts:

Rx Deductible- 100%
Rx Copay- 80%
(after medical deductible)

Call 888.343.2110 with any questions.

Download the Mobile App to View and Submit Claims



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