The Difference Card

# SUMMARY OF BENEFITS

**Conover Advertising** | **HPHC PPO** | **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 | $5,000 | $5,000 |
| **In-Network Family Deductible** | $0 | $10,000 | $10,000 |
| **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** | First $2,000 | Remaining $6,000 | $8,000 |
| **Out-of-Network Family Deductible** | First $4,000 | Remaining $12,000 | $16,000 |
| **Out-of-Network Individual Coinsurance Limit** | First $2,000 | Remaining $4,000 | 20% to $6,000 |
| **Out-of-Network Family Coinsurance Limit** | First $4,000 | Remaining $8,000 | 20% to $12,000 |

**In-Network Family Multiplier** 2 **Out-of-Network Family Multiplier** 2 **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.

All Out-of-Network Services are subject to the Deductible.

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

SCAN THIS WITH YOUR CAMERA