The Difference Card

SUMMARY OF BENEFITS

Institute on Aging | **United Healthcare UHC PPO Core** | **7/1/2025** to **6/30/2026**

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

TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	UHC BENEFIT
PHYSICIAN SERVICES			
Primary Care Office Visit Copay	$0	$30	$30 Copay
Specialist Office Visit Copay	$0	$60	$60 Copay
Preventive Care / Screening / Immunization	No Charge		
Urgent Care	$0	$30	$30 Copay
PHARMACY			
Retail Prescriptions	T1-3 $10/$35/$70 T4 $10/$150/$250	$0	T1-3 $10/$35/$70 T4 $10/$150/$250
Mail Order Prescriptions	$25/$87.50/$175	$0	$25/$87.50/$175
DIAGNOSTIC PROCEDURES			
Diagnostic Test- Lab Bloodwork	Remaining Amount	First $3,500/$7,000	Deductible and Coinsurance
Diagnostic Test X-Ray	Remaining Amount	First $3,500/$7,000	Deductible and Coinsurance
Complex Imaging (CT/Pet Scans, MRIs)	Remaining Amount	First $3,500/$7,000	Deductible and Coinsurance
HOSPITAL SERVICES			
Emergency Room Care	Remaining Amount	First $3,500/$7,000	Deductible and Coinsurance
Outpatient Surgery	Remaining Amount	First $3,500/$7,000	Deductible and Coinsurance
Inpatient Hospital	Remaining Amount	First $3,500/$7,000	Deductible and Coinsurance
IN NETWORK DEDUCTIBLE & COINSURANCE			
Qualified High Deductible Health Plan	No		
Deductible Accumulation Period	Calendar year		
Family Deductible Accumulation Type	Individual Accumulation		
In-Network Individual Deductible	$0	$3,500	$3,500
In-Network Family Deductible	$0	$7,000	$7,000
In-Network Individual Coinsurance Limit	$3,500	$0	30% to $3,500
In-Network Family Coinsurance Limit	$7,000	$0	30% to $7,000
OUT OF NETWORK DEDUCTIBLE & COINSURANCE			
Out-of-Network Individual Deductible	$10,500	$0	$10,500
Out-of-Network Family Deductible	$21,000	$0	$21,000
Out-of-Network Individual Coinsurance Limit	$12,000	$0	50% to $12,000
Out-of-Network Family Coinsurance Limit	$24,000	$0	50% to $24,000

In-Network Family Multiplier 2 **Mail Order Multiplier** 2.5

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:

Primary Care Swipe -	$30
Specialist Swipe -	$60
Urgent Care Swipe -	$30
Deductible Expenses -	First $3,500/$7,000

Call 888.343.2110 with any questions.

Download the Mobile App to View and Submit Claims

SCAN THIS WITH YOUR CAMERA