The Difference Card

# SUMMARY OF BENEFITS

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

**UHC PPO Select Plus**

**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 |
| **Specialist Office Visit Copay** | $0 | $60 | $60 |
| **Preventive Care / Screening / Immunization** | No Charge | | |
| **Urgent Care** | $0 | $30 | $30 |
| **PHARMACY** | | | |
| **Retail Prescriptions** | T1-3 $10/$35/$70<br>T4 $10/$150/$250 | $0 | T1-3 $10/$35/$70<br>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** | Yes | | |
| **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** | $10,500 | $0 | 50% to $10,500 |
| **Out-of-Network Family Coinsurance Limit** | $21,000 | $0 | 50% to $21,000 |

**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