

WELCOME TO YOUR DIFFERENCE CARD BENEFITS!

The Difference Card is a benefit funded by your employer that helps you save money on your medical costs.



Hi I'm Danny! I'm here to help you understand how to use your Difference Card benefits with your health insurance.

GETTING STARTED

MOBILE APP

Using your smart phone's camera, scan this to download mobile app.

With The Difference Card Smart Mobile App, you can:

- Snap a picture to easily submit your claim
- Find the cheapest place to buy your prescriptions
- Compare cost and search for providers
- View your account balance
- Check claim status
- Sign up for Direct Deposit

LEARN MORE

Visit us online at <u>DifferenceCard.com</u>.

Questions? Our Customer Care Team is available Monday - Friday, from 8AM to 9PM ET.

Call us at (888) 343-2110

The Difference Card SUMMARY OF BENEFITS					
Institute on Aging	Kaiser		o 6/30/2026		
HMO Plan (California) Swipe card for benefit listed under the "Difference Card Pays" column.					
TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAY	S KAISER BENEFIT		
	PHYSICIAN SERVICES				
Primary Care Office Visit Copay	Remaining Amount	First \$3,000/\$6,000	Deductible and Coinsurance		
Specialist Office Visit Copay	Remaining Amount	First \$3,000/\$6,000	Deductible and Coinsurance		
Preventive Care / Screening / Immunization		No Charge			
IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	Remaining Amount	First \$3,000/\$6,000	Deductible and Coinsurance		
	PHARMACY				
Retail Prescriptions	\$25/\$50/\$125/\$75	50%	30% to \$50/\$100/\$250 20% to \$150		
Mail Order Prescriptions	\$25/\$50/\$125	50%	30% to \$50/\$100/\$250		
	DIAGNOSTIC PROCEDU	RES			
Diagnostic Test- Lab Bloodwork	Remaining Amount	First \$3,000/\$6,000	Deductible and		
Diagnostic Test X-Ray	Remaining Amount	First \$3,000/\$6,000	Coinsurance Deductible and		
Complex Imaging (CT/Pet Scans, MRIs)	Remaining Amount	First \$3,000/\$6,000	Coinsurance Deductible and Coinsurance		
	HOSPITAL SERVICES				
Emergency Room Care	Remaining Amount	First \$3,000/\$6,000	Deductible and		
Outpatient Surgery	Remaining Amount	First \$3,000/\$6,000	<u>Coinsurance</u> Deductible and Coinsurance		
Inpatient Hospital	Remaining Amount	First \$3,000/\$6,000	Deductible and Coinsurance		
IN NET	WORK DEDUCTIBLE & COI	NSURANCE			
Qualified High Deductible Health Plan	No				
Deductible Accumulation Period					
Family Deductible Accumulation Type	Family Total Accumulation				
In-Network Individual Deductible	\$0	■ \$3,000	\$3,000		
In-Network Family Deductible	\$0	= = \$6,000	\$6,000		
In-Network Individual Coinsurance Limit	\$3,000	\$0	30% to \$3,000		
In-Network Family Coinsurance Limit	\$6,000	\$0	30% to \$6,000		
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.	Difference Card fo Primary Care Swipe - Specialist Swipe - UC & ER Visit Swipe - Deductible Expenses - RX Copay -	First \$3,000/\$6,000 First \$3,000/\$6,000 First \$3,000/\$6,000	Mail Order Multiplier 2 Download the Mobile App to View and Submit Claims Scan This With Your camera		

UHC PPO Core r benefit listed under the "Diffe YOU PAY PHYSICIAN SERVICES \$0 \$0 \$0 PHARMACY T1-3 \$10/\$35/\$70 T4 \$10/\$150/\$250 \$25/\$87.50/\$175 DIAGNOSTIC PROCEDUI Remaining Amount	DIFFERENCE CARD PAY \$30 \$30 \$60 No Charge \$30 \$30 \$30	S UHC BENEFIT \$30 Copay \$60 Copay \$30 Copay \$30 Copay 11-3 \$10/\$35/\$70 T4 \$10/\$150/\$250 \$25/\$87.50/\$175
PHYSICIAN SERVICES \$0 \$0 \$0 \$0 \$0 \$1 \$0 \$1 \$1 \$1 \$10 \$25/\$87.50/\$175	\$30 \$60 No Charge \$30 \$0 \$0	\$30 Copay \$60 Copay \$30 Copay 11-3 \$10/\$35/\$70 T4 \$10/\$150/\$250
\$0 \$0 \$0 PHARMACY 11-3 \$10/\$35/\$70 14 \$10/\$150/\$250 \$25/\$87.50/\$175 DIAGNOSTIC PROCEDU	\$30 \$60 No Charge \$30 \$0 \$0	\$60 Copay \$30 Copay T1-3 \$10/\$35/\$70 T4 \$10/\$150/\$250
\$0 \$0 PHARMACY T1-3 \$10/\$35/\$70 T4 \$10/\$150/\$250 \$25/\$87.50/\$175 DIAGNOSTIC PROCEDU	\$60 No Charge \$30 \$0 \$0	\$60 Copay \$30 Copay T1-3 \$10/\$35/\$70 T4 \$10/\$150/\$250
\$0 PHARMACY T1-3 \$10/\$35/\$70 T4 \$10/\$150/\$250 \$25/\$87.50/\$175 DIAGNOSTIC PROCEDU	No Charge \$30 \$0 \$0	\$30 Copay T1-3 \$10/\$35/\$70 T4 \$10/\$150/\$250
PHARMACY T1-3 \$10/\$35/\$70 T4 \$10/\$150/\$250 \$25/\$87.50/\$175 DIAGNOSTIC PROCEDU	\$30 \$0 \$0	T1-3 \$10/\$35/\$70 T4 \$10/\$150/\$250
PHARMACY T1-3 \$10/\$35/\$70 T4 \$10/\$150/\$250 \$25/\$87.50/\$175 DIAGNOSTIC PROCEDU	\$0 \$0	T1-3 \$10/\$35/\$70 T4 \$10/\$150/\$250
T1-3 \$10/\$35/\$70 T4 \$10/\$150/\$250 \$25/\$87.50/\$175 DIAGNOSTIC PROCEDU	\$0	T4 \$10/\$150/\$250
T4 \$10/\$150/\$250 \$25/\$87.50/\$175 DIAGNOSTIC PROCEDU	\$0	T4 \$10/\$150/\$250
\$25/\$87.50/\$175	<u> </u>	
Remaining Amount	RES	
-	First \$3,500/\$7,000	Deductible and Coinsurance
Remaining Amount	First \$3,500/\$7,000	Deductible and Coinsurance
Remaining Amount	First \$3,500/\$7,000	Deductible and Coinsurance
HOSPITAL SERVICES		
Remaining Amount	First \$3,500/\$7,000	Deductible and Coinsurance
Remaining Amount	First \$3,500/\$7,000	Deductible and
Remaining Amount	First \$3,500/\$7,000	<u>Coinsurance</u> Deductible and
VORK DEDUCTIBLE & COI	NSURANCE	Coinsurance
	No	
	Calendar year	
	Individual Accumulation	<u>n</u>
\$ 0	\$3,500	\$3,500
\$O	\$7,000	\$7,000
\$3,500	\$0	30% to \$3,500
\$7,000	\$O	30% to \$7,000
ETWORK DEDUCTIBLE & C	OINSURANCE	
\$10,500	\$0	\$10,500
\$21,000	\$0	\$21,000
\$12,000	\$0	50% to \$12,000
\$24,000	\$0	50% to \$24,000
	ur provider swise the	Mail Order Multiplier 2.5
Difference Card fo Primary Care Swipe - Specialist Swipe - Urgent Care Swipe -	r the following amounts: \$30 \$60 \$30	Download he Mobile App to View and
Deductible Expenses -	First \$3,500/\$7,000	Submit Claims scan this with your camer
	HOSPITAL SERVICES Remaining Amount Remaining Amount Remaining Amount VORK DEDUCTIBLE & COI \$0 \$0 \$0 \$0 \$0 \$10,500 \$7,000 ETWORK DEDUCTIBLE & C \$10,500 \$12,000 \$10,500	HOSPITAL SERVICES Remaining Amount First \$3,500/\$7,000 Remaining Amount First \$3,500/\$7,000 Remaining Amount First \$3,500/\$7,000 Remaining Amount First \$3,500/\$7,000 VORK DEDUCTIBLE & COINSURANCE No Calendar year Individual Accumulation \$0 €== \$7,000 \$0 €== \$7,000 \$10,500 \$0 \$0 \$10,500 \$0 \$0 \$10,500 \$0 \$0 \$21,000 \$0 \$12,000 \$0 \$24,000 \$0 \$21,000 \$0 \$21,000 \$0 \$0 \$12,000 \$0 \$21,000 \$0 \$0 \$12,000 \$0 \$21,000 \$0 \$0 \$12,000 \$0 \$0 \$21,000 \$0 \$0 \$12,000 \$0 \$12,000 \$0 \$20 \$12,000 \$0 \$0 \$12,000 \$0 \$12,000 \$0 \$20 \$12,000 \$0 \$0 \$12,000 \$0 \$12,000

Institute on Aging Swipe card for	United Healthcare UHC PPO Select Plu or benefit listed under the "Diffe		6/30/2026
TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAY	S UHC BENEFIT
	PHYSICIAN SERVICES		
Primary Care Office Visit Copay	\$O	\$30	\$30
Specialist Office Visit Copay	\$O	\$60	\$60
Preventive Care / Screening / Immunization		No Charge	
Urgent Care	\$O	\$30	\$30
	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	\$O	\$25/\$87.50/\$175
	DIAGNOSTIC PROCEDU	RES	
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
Inpatient Hospital	Remaining Amount	First \$3,500/\$7,000	<u>Coinsurance</u> Deductible and
	NORK DEDUCTIBLE & COI	· ·	Coinsurance
Qualified High Deductible Health Plan		Yes	
Deductible Accumulation Period		Calendar year	
Family Deductible Accumulation Type		Individual Accumulation	n
In-Network Individual Deductible	\$O	\$ 3,500	\$3,500
In-Network Family Deductible	\$O	\$7,000	\$7,000
In-Network Individual Coinsurance Limit	\$3,500	\$O	30% to \$3,500
In-Network Family Coinsurance Limit	\$7,000	\$O	30% to \$7,000
OUT OF N	ETWORK DEDUCTIBLE & C	OINSURANCE	
Out-of-Network Individual Deductible	\$10,500	\$0	\$10,500
Out-of-Network Family Deductible	\$21,000	\$O	\$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 Mail Order Multiplier 2.5
All claims must be submitted within 3 months of the end of he deductible accumulation period. erminated members must submit claims within 3 months of the ermination date. All Out-of-Network Services are subject to the Deductible. Information on this document based on carrier SBC.	Difference Card fo Primary Care Swipe - Specialist Swipe - Urgent Care Swipe - Deductible Expenses -	\$60 \$30 First \$3.500/\$7.000	Download ne Mobile App to View and Submit Claims

WAYS TO SUBMIT YOUR CLAIM



MOBILE

Download the Difference Card Smart Mobile App to submit your claim with a picture.



ONLINE

Login to your account at **DifferenceCard.com** to submit your claim online.



MAIL

PO Box 322

Mount Kisco, NY

10549

*Reimbursement is

Required



FAX

(602) 333-4252 *Reimbursement is Required



DIRECT DEPOSIT

The fastest way to get your money.

Money will come back to you via direct deposit if you select that as your Reimbursement Preference.

TOOLS ON THE GO

Scan this code with your camera app to get helpful resources at your fingertips.

