

<div><div></div><div>The Difference Card</div></div> <div>SUMMARY OF BENEFITS</div> <div><div>Institute on Aging</div><div>United Healthcare</div><div>7/1/2025</div><div>to</div><div>6/30/2026</div></div> <div>UHC PPO Core</div>			
<div><div></div><div>Swipe card for benefit listed under the "Difference Card Pays" column.</div></div>			
TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	UHC BENEFIT
PHYSICIAN SERVICES			
<div></div> Primary Care Office Visit Copay	\$0	\$30	\$30 Copay
<div></div> Specialist Office Visit Copay	\$0	\$60	\$60 Copay
Preventive Care / Screening / Immunization	No Charge		
<div></div> 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			
<div></div> Diagnostic Test- Lab Bloodwork	Remaining Amount	First \$3,500	Deductible and Coinsurance
<div></div> Diagnostic Test X-Ray	Remaining Amount	First \$3,500	Deductible and Coinsurance
<div></div> Complex Imaging (CT/Pet Scans, MRIs)	Remaining Amount	First \$3,500	Deductible and Coinsurance
HOSPITAL SERVICES			
<div></div> Emergency Room Care	Remaining Amount	First \$3,500	Deductible and Coinsurance
<div></div> Outpatient Surgery	Remaining Amount	First \$3,500	Deductible and Coinsurance
<div></div> Inpatient Hospital	Remaining Amount	First \$3,500	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	<div></div> \$3,500	\$3,500
In-Network Family Deductible	\$3,500	<div></div> \$3,500	\$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
<div><div>In-Network Family Multiplier2</div><div>Mail Order Multiplier2.5</div></div>			
<div><div><div>All claims must be submitted within 3 months of the end of the deductible accumulation period.</div><div>Terminated members must submit claims within 3 months of the termination date.</div><div>All Out-of-Network Services are subject to the Deductible.</div><div>Information on this document based on carrier SBC.</div></div><div><div><div></div><div>Please have your provider swipe the Difference Card for the following amounts:</div><div>Primary Care Swipe - \$30</div><div>Specialist Swipe - \$60</div><div>Urgent Care Swipe - \$30</div><div>Deductible Expenses - First \$3,500</div><div>Call 888.343.2110 with any questions.</div></div><div><div>Download the Mobile App to View and Submit Claims</div><div><div></div><div>SCAN THIS WITH YOUR CAMERA</div></div></div></div></div>			