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 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	Deductible and Coinsurance
Diagnostic Test X-Ray	Remaining Amount	First $3,500	Deductible and Coinsurance
Complex Imaging (CT/Pet Scans, MRIs)	Remaining Amount	First $3,500	Deductible and Coinsurance
HOSPITAL SERVICES			
Emergency Room Care	Remaining Amount	First $3,500	Deductible and Coinsurance
Outpatient Surgery	Remaining Amount	First $3,500	Deductible and Coinsurance
Inpatient Hospital	Remaining Amount	First $3,500	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	$3,500	$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	$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

Call 888.343.2110 with any questions.

Download the Mobile App to View and Submit Claims

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