

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



SUMMARY OF BENEFITS

7/1/2024 Institute on Aging Kaiser 6/30/2025

HMO Plan (California)

HMO Plan (California)						
TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	KAISER BENEFIT			
	DEDUCTIBLE & COINSURA					
Qualified High Deductible Health Plan		No				
Deductible Accumulation Period		Calendar Year				
Family Deductible Accumulation Type	1 1 4 500	Yes	#0.000			
In-Network Individual Deductible	Last \$500	First \$2,500	\$3,000			
In-Network Family Deductible	Last \$3,500	First \$2,500	\$6,000			
Out-of-Network Individual Deductible		No out of Network				
Out-of-Network Family Deductible						
Prescription Deductible Application Prescription Individual Deductible		N/A				
	No Prescription Deductible					
Prescription Family Deductible In-Network Coinsurance %	30%	0%	30%			
In-Network Individual Coinsurance Limit	\$3,000	\$0	\$3,000			
In-Network Family Coinsurance Limit	\$6,000	\$0 \$0	\$6,000			
Out-of-Network Coinsurance %	ψ0,000	ΨΟ	ψ0,000			
Out-of-Network Individual Coinsurance Limit		No out of Network				
Out-of-Network Family Coinsurance Limit		THE COT OF THE TWO IN				
In/Out Network Cross Accumulation		No				
	PHYSICIAN SERVICES					
Primary Care Office Visit Copay	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Specialist Office Visit Copay	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Telemedicine Copay		No Charge				
Other (Chiro) Office Copay	N/A	N/A	N/A			
Proceeding Comments of Lorentz of	PREVENTIVE CARE	No Clearers				
Preventive Care / Screening / Immunization	DIAGNOSTIC PROCEDUR	No Charge				
Diagnostic Test X-Ray	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Diagnostic Test- Lab Bloodwork	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Imaging (CT/Pet Scans, MRIs)	Remaining Charges	First \$2,500	Deductible & Coinsurance			
gg (c-, - c- c	PHARMACY	7.55				
Tier 1 RX Retail Copay	\$0	100%	30% up to \$50			
Tier 1 RX Mail Order Copay	Ψο	100% up to \$50	3070 00 10 400			
Tier 2 RX Retail Copay	\$0	100% up to \$100	30% up to \$100			
Tier 2 RX Mail Order Copay	ΨΟ	100% 00 10 \$100	20,0 00 10 4100			
Tier 3 RX Retail Copay	\$0	100% up to \$250	30% up to \$250			
Tier 3 RX Mail Order Copay		• •				
Tier 4 RX Retail Copay	\$0	100% up to \$150	20% up to \$150			
Tier 4 RX Mail Order Copay	N/A MAJOR MEDICAL SERVIC	N/A	N/A			
Outpatient Surgery Facility Fee	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Outpatient Surgery Physician / Surgeon Fee	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Emergency Room Care	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Emergency Medical Transportation	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Urgent Care	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Inpatient Hospital Facility Fee	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Inpatient Surgery Physician / Surgeon Fee	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Behavioral Health Outpatient Services	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Behavioral Health Inpatient Services	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Prenatal and Postnatal Care		No Charge				
Delivery and All Inpatient Services	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Home Health Care		No Charge				
Rehabilitation Services	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Habilitative Services	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Skilled Nursing Care	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Durable Medical Equipment	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Hospice Service	-	No Charge				
- 0 0 -	_					

Family Multiplier

Please have your provider swipe the Difference Card for the following amounts:

deductible accumulation period. Terminated members must submit claims within 3 months of

All claims must be submitted within 3 months of the end of the

the termination date.

Information on this document based on carrier SBC

Primary Care & Specialist Swipe -First \$2,500

ER Visit Swipe -First \$2,500 Urgent Care Swipe -First \$2,500 Rx Swipe -100% up to \$250

Deductible Expenses -Up to \$2500 Call 888.343.2110 with any questions.

Download the Mobile App to View and **Submit Claims**

Mail Order Multiplier





SUMMARY OF BENEFITS

Institute on Aging

United Healthcare

7/1/2024 to 6/30/2025

Core PPO Plan

Core PPO Plan						
TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	UHC BENEFIT			
Qualified High Deductible Health Plan	DEDUCTIBLE & COINSURA	NCE No				
Deductible Accumulation Period	Calendar Year					
Family Deductible Accumulation Type	1	Embedded	#0.500			
In-Network Individual Deductible	Last \$500	First \$3,000	\$3,500			
In-Network Family Deductible	Last \$4,000	First \$3,000	\$7,000			
Out-of-Network Individual Deductible	\$10,500	\$0	\$10,500			
Out-of-Network Family Deductible	\$21,000	\$0	\$21,000			
Prescription Deductible Application		N/A				
Prescription Individual Deductible		No Prescription Deductible				
Prescription Family Deductible			1			
In-Network Coinsurance %	30%	0%	30%			
In-Network Individual Coinsurance Limit	\$3,500	\$0	\$3,500			
In-Network Family Coinsurance Limit	\$7,000	\$0	\$7,000			
Out-of-Network Coinsurance %	50%	0%	50%			
Out-of-Network Individual Coinsurance Limit	\$10,500	\$0	\$10,500			
Out-of-Network Family Coinsurance Limit	\$21,000	\$0	\$21,000			
In/Out Network Cross Accumulation		No				
	PHYSICIAN SERVICES	600	#00 G			
Primary Care Office Visit Copay	\$0	\$30	\$30 Copay			
Specialist Office Visit Copay	\$0	\$60	\$60 Copay			
Telemedicine Copay		No Charge	1			
Other (Chiro) Office Copay	\$0	\$30	\$30 Copay			
D	PREVENTIVE CARE	No Charas				
Preventive Care / Screening / Immunization	DIAGNOSTIC PROCEDU	No Charge				
Diagnostic Test X-Ray	Remaining Charges	First \$3,000	Deductible & Coinsurance			
Diagnostic Test- Lab Bloodwork	Remaining Charges	First \$3,000	Deductible & Coinsurance			
Imaging (CT/Pet Scans, MRIs)	Remaining Charges	First \$3,000	Deductible & Coinsurance			
inaging (Ci/i et scans, Mikis)	PHARMACY	1 1131 \$0,000	Beaterible & Comstraince			
Tier 1 RX Retail Copay	\$10.00	\$0.00	\$10.00			
Tier 1 RX Mail Order Copay	\$25.00	\$0.00	\$25.00			
Tier 2 RX Retail Copay	\$35.00	\$0.00	\$35.00			
Tier 2 RX Mail Order Copay	\$87.50	\$0.00	\$87.50			
Tier 3 RX Retail Copay	\$70.00	\$0.00	\$70.00			
Tier 3 RX Mail Order Copay	\$175.00	\$0.00	\$175.00			
Tier 4 RX Retail Copay	\$10/\$150/\$250	\$0.00	\$10/\$150/\$250			
Tier 4 RX Mail Order Copay	N/A	\$0.00	N/A			
ner 4 nx man order copay	MAJOR MEDICAL SERVI		1477			
Outpatient Surgery Facility Fee	Remaining Charges	First \$3,000	Deductible & Coinsurance			
Outpatient Surgery Physician / Surgeon Fee	Remaining Charges	First \$3,000	Deductible & Coinsurance			
Emergency Room Care	Remaining Charges	First \$3,000	Deductible & Coinsurance			
Emergency Medical Transportation	Remaining Charges	First \$3,000	Deductible & Coinsurance			
Urgent Care	\$0 Copay	\$50	\$50			
Inpatient Hospital Facility Fee	Remaining Charges	First \$3,000	Deductible & Coinsurance			
Inpatient Surgery Physician / Surgeon Fee	Remaining Charges	First \$3,000	Deductible & Coinsurance			
Behavioral Health Outpatient Services	\$0	\$30	\$30 Copay			
Behavioral Health Inpatient Services	Remaining Charges	First \$3,000	Deductible & Coinsurance			
Prenatal and Postnatal Care		No Charge				
Delivery and All Inpatient Services	Remaining Charges	First \$3,000	Deductible & Coinsurance			
Home Health Care	Remaining Charges	First \$3,000	Deductible & Coinsurance			
Rehabilitation Services	\$0	\$30	\$30 Copay			
Habilitative Services	\$0 \$0	\$30	\$30 Copay			
Skilled Nursing Care	Remaining Charges	First \$3,000	Deductible & Coinsurance			
Durable Medical Equipment	Remaining Charges	First \$3,000	Deductible & Coinsurance			
Hospice Service	Remaining Charges	First \$3,000	Deductible & Coinsurance			
Family Multiplier 2			Mail Order Multiplie 2.5			

Please have your provider swipe the Difference Card

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

for the following amounts: Primary Care Swipe -\$30 Specialist Swipe -\$60 Urgent Care Swipe -\$50 Deductible Expense Up to \$3,000

Call 888.343.2110 with any questions.

Download the Mobile App to View and **Submit Claims**



SCAN THIS WITH YOUR CAMERA



SUMMARY OF BENEFITS

Institute on Aging

United Healthcare

7/1/2024

to

6/30/2025

Select Plus PPO Plan

	Select Plus PPO Plan		
TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	UHC BENEFIT
Overliff and I if the Dendura Wale I have the Disco	DEDUCTIBLE & COINSUR		
Qualified High Deductible Health Plan		No	
Deductible Accumulation Period		Calendar Year	
Family Deductible Accumulation Type		Embedded	
In-Network Individual Deductible	Last \$500	First \$3000	\$3,500
In-Network Family Deductible	Last \$4,000	First \$3,000	\$7,000
Out-of-Network Individual Deductible	\$6,000	\$0	\$10,500
Out-of-Network Family Deductible	\$12,000	\$0	\$21,000
Prescription Deductible Application		N/A	
Prescription Individual Deductible		No Prescription Deductible	
Prescription Family Deductible		No i rescription bedoctible	
In-Network Coinsurance %	30%	0%	30%
In-Network Individual Coinsurance Limit	\$3,500	\$0	\$3,500
In-Network Family Coinsurance Limit	\$7,000	\$0	\$7,000
Out-of-Network Coinsurance %	50%	0%	50%
Out-of-Network Individual Coinsurance Limit	\$10,500	\$0	\$10,500
Out-of-Network Family Coinsurance Limit	\$21,000	\$0	\$21,000
In/Out Network Cross Accumulation	, , , , , , ,	0	1 /222
	PHYSICIAN SERVICE	\$	
Primary Care Office Visit Copay	\$0	\$30	\$30 Copay
Specialist Office Visit Copay	\$0	\$60	\$60 Copay
Telemedicine Copay		No Charge	
Other (Chiro) Office Copay	\$0	\$30	\$30 Copay
	PREVENTIVE CARE		1 4
Preventive Care / Screening / Immunization		No Charge	
	DIAGNOSTIC PROCED	U ICEU	
Diagnostic Test X-Ray	Remaining Charges	First \$3,000	Deductible & Coinsuranc
Diagnostic Test- Lab Bloodwork	Remaining Charges	First \$3,000	Deductible & Coinsuranc
Imaging (CT/Pet Scans, MRIs)	Remaining Charges	First \$3,000	Deductible & Coinsuranc
	PHARMACY		
Tier 1 RX Retail Copay	\$10.00	\$0.00	\$10.00
Tier 1 RX Mail Order Copay	\$25.00	\$0.00	\$25.00
Tier 2 RX Retail Copay	\$35.00	\$0.00	\$35.00
Tier 2 RX Mail Order Copay	\$87.50	\$0.00	\$87.50
Tier 3 RX Retail Copay	\$70.00	\$0.00	\$70.00
Tier 3 RX Mail Order Copay	\$175.00	\$0.00	\$175.00
Tier 4 RX Retail Copay	\$10/\$150/\$250	\$0.00	\$10/\$150/\$250
Tier 4 RX Mail Order Copay	N/A	\$0.00	N/A
	MAJOR MEDICAL SERV		
Outpatient Surgery Facility Fee	Remaining Charges	First \$3,000	Deductible & Coinsuranc
Outpatient Surgery Physician / Surgeon Fee	Remaining Charges	First \$3,000	Deductible & Coinsurance
Emergency Room Care	Remaining Charges	First \$3,000	Deductible & Coinsurance
Emergency Medical Transportation	Remaining Charges	First \$3,000	Deductible & Coinsuranc
Urgent Care	\$0 Copay	\$50	\$50
Inpatient Hospital Facility Fee	Remaining Charges	First \$3,000	Deductible & Coinsuranc
Inpatient Surgery Physician / Surgeon Fee	Remaining Charges	First \$3,000	Deductible & Coinsuranc
Behavioral Health Outpatient Services	\$0	\$30	\$30 Copay
Behavioral Health Inpatient Services	Remaining Charges	First \$3,000	Deductible & Coinsurance
Prenatal and Postnatal Care	5 5	No Charge	,
Delivery and All Inpatient Services	Remaining Charges	First \$3,000	Deductible & Coinsurance
Home Health Care	Remaining Charges	First \$3,000	Deductible & Coinsurance
Rehabilitation Services	\$0	\$30	\$30 Copay
Habilitative Services	\$0 \$0	\$30	\$30 Copay
	•	\$30 First \$3,000	Deductible & Coinsurance
Skilled Nursing Care	Remaining Charges		
Durable Medical Equipment	Remaining Charges	First \$3,000	Deductible & Coinsuranc
Hospice Service Family Multiplier	Remaining Charges	First \$3,000	Deductible & Coinsurance

Please have your provider swipe the Difference Card for the following amounts:

Terminated members must submit claims within 3 months of

Urgent Care Swipe -Deductible Expense

Primary Care Swipe -

Specialist Swipe -

\$60 \$50 Up to \$3,000

\$30

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All Out-of-Network Services are subject to the Deductible Information on this document based on carrier SBC

All claims must be submitted within 3 months of the end of the

deductible accumulation period.

the termination date.

SCAN THIS WITH

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.



