The Difference Card

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.

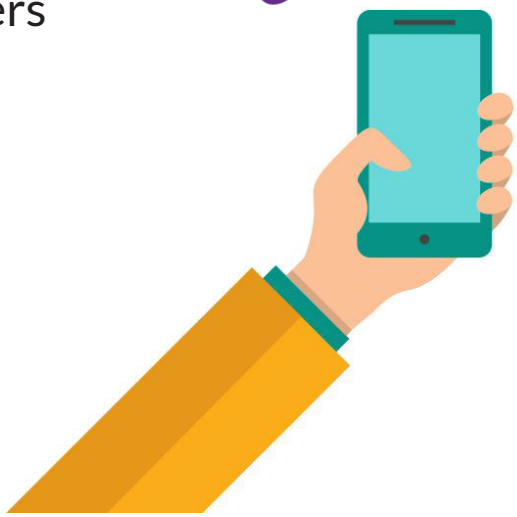
GETTING STARTED

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 DifferenceCard.com .

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 | **United Healthcare UHC PPO Core** | **7/1/2026** to **6/30/2027**

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 Copay
Specialist Office Visit Copay	$0	$60	$60 Copay
Preventive Care / Screening / Immunization	No Charge		
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			
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	No		
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	$12,000	$0	50% to $12,000
Out-of-Network Family Coinsurance Limit	$24,000	$0	50% to $24,000

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.

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

SCAN THIS WITH YOUR CAMERA

The Difference Card

SUMMARY OF BENEFITS

Institute on Aging | **United Healthcare** | **7/1/2026** to **6/30/2027**

UHC PPO Select Plus

Swipe card for benefit listed under the "Difference Card Pays" column.

TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	UNITED HEALTHCARE BENEFIT
PHYSICIAN SERVICES			
Primary Care Office Visit Copay	$0	$30	$30 Copay
Specialist Office Visit Copay	$0	$60	$60 Copay
Preventive Care / Screening / Immunization	No Charge		
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			
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.

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

SCAN THIS WITH YOUR CAMERA

The Difference Card

SUMMARY OF BENEFITS

Institute on Aging | **Kaiser** | **7/1/2026** to **6/30/2027**

HMO Plan (California)

Swipe card for benefit listed under the "Difference Card Pays" column.

TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	KAISER BENEFIT
PHYSICIAN SERVICES			
Primary Care Office Visit Copay	Remaining Amount	First $3,000	Deductible and Coinsurance
Specialist Office Visit Copay	Remaining Amount	First $3,000	Deductible and Coinsurance
Preventive Care / Screening / Immunization	No Charge		
Urgent Care	Remaining Amount	First $3,000	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 PROCEDURES			
Diagnostic Test- Lab Bloodwork	Remaining Amount	First $3,000	Deductible and Coinsurance
Diagnostic Test X-Ray	Remaining Amount	First $3,000	Deductible and Coinsurance
Complex Imaging (CT/Pet Scans, MRIs)	Remaining Amount	First $3,000	Deductible and Coinsurance
HOSPITAL SERVICES			
Emergency Room Care	Remaining Amount	First $3,000	Deductible and Coinsurance
Outpatient Surgery	Remaining Amount	First $3,000	Deductible and Coinsurance
Inpatient Hospital	Remaining Amount	First $3,000	Deductible and Coinsurance
IN NETWORK DEDUCTIBLE & COINSURANCE			
Qualified High Deductible Health Plan	No		
Deductible Accumulation Period	Calendar year		
Family Deductible Accumulation Type	Family Total Accumulation		
In-Network Individual Deductible	$0	$3,000	$3,000
In-Network Family Deductible	$3,000	$3,000	$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

In-Network Family Multiplier 2 **Mail Order Multiplier** 2

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.

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

Primary Care Swipe - First $3,000
Specialist Swipe - First $3,000
UC & ER Visit Swipe - First $3,000
Deductible Expenses - First $3,000
RX Copay - 50%

Call 888.343.2110 with any questions.

Download the Mobile App to View and Submit Claims

SCAN THIS WITH YOUR CAMERA

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.

SCAN ME