The Difference Card

SUMMARY OF BENEFITS

Peru Public School District #124 | **UHC 3350 PPO** | **9/1/2026** to **8/31/2027**

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	Remaining Costs	First $3,350/$6,700	Deductible
Specialist Office Visit Copay	Remaining Costs	First $3,350/$6,700	Deductible
Preventive Care / Screening / Immunization	No Charge		
Urgent Care	Remaining Costs	First $3,350/$6,700	Deductible
PHARMACY			
Prescription Deductible Application	Integrated with Medical Deductible		
Prescription Individual Deductible	20%	First $3,350/$6,700, then 80%	Integrates w/ Medical Deductible
Prescription Family Deductible			
Retail Prescriptions			
Mail Order Prescriptions			
DIAGNOSTIC PROCEDURES			
Diagnostic Test- Lab Bloodwork	Remaining Costs	First $3,350/$6,700	Deductible
Diagnostic Test X-Ray	Remaining Costs	First $3,350/$6,700	Deductible
Complex Imaging (CT/Pet Scans, MRIs)	Remaining Costs	First $3,350/$6,700	Deductible
HOSPITAL SERVICES			
Emergency Room Care	Remaining Costs	First $3,350/$6,700	Deductible
Outpatient Surgery	Remaining Costs	First $3,350/$6,700	Deductible
Inpatient Hospital	Remaining Costs	First $3,350/$6,700	Deductible
IN NETWORK DEDUCTIBLE & COINSURANCE			
Qualified High Deductible Health Plan	No		Yes
Deductible Accumulation Period	Calendar year		
Family Deductible Accumulation Type	Family Total Accumulation		Individual Accumulation
In-Network Individual Deductible	Last $3,000/$6,000	First $3,350/$6,700	$6,350
In-Network Family Deductible			$12,700
OUT OF NETWORK DEDUCTIBLE & COINSURANCE			
Out-of-Network Individual Deductible	$10,000	$0	$10,000
Out-of-Network Family Deductible	$20,000		$20,000
Out-of-Network Individual Coinsurance Limit	20% to $10,000		20% to $10,000
Out-of-Network Family Coinsurance Limit	20% to $20,000		20% to $20,000

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:

In-Network Medical- & Rx Swipe- First $3,350/$6,700, then 80% for Rx

Call 888.343.2110 with any questions.

Download the Mobile App to View and Submit Claims

SCAN THIS WITH YOUR CAMERA