

















<div>The Difference Card</div> <div>SUMMARY OF BENEFITS</div> <div>EK Health Services IncKaiser1/1/2025to12/31/2025HMO</div>			
<div>Swipe card for benefit listed under the "Difference Card Pays" column.</div>			
TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	Kaiser BENEFIT
PHYSICIAN SERVICES			
<div>Primary Care Office Visit Copay</div>	\$0 Ded then \$40	Deductible	Deductible then \$40
<div>Specialist Office Visit Copay</div>	\$0 Ded then \$50	Deductible	Deductible then \$50
Preventive Care / Screening / Immunization	No Charge		
<div>Urgent Care</div>	\$0 Ded then \$40	Deductible	Deductible then \$40
PHARMACY			
<div>Prescription Deductible Application</div>	Integrated with Medical Deductible		
Retail Prescriptions	\$15 / \$35 / 30% to \$250	\$0	\$15 / \$35 / 30% to \$250
Mail Order Prescriptions	\$30 / \$70	\$0	\$30 / \$70
DIAGNOSTIC PROCEDURES			
<div>Diagnostic Test- Lab Bloodwork</div>	Coinsurance	Deductible	Deductible and Coinsurance
<div>Diagnostic Test X-Ray</div>	Coinsurance	Deductible	Deductible and Coinsurance
<div>Complex Imaging (CT/Pet Scans, MRIs)</div>	Coinsurance	Deductible	Deductible and Coinsurance
HOSPITAL SERVICES			
<div>Emergency Room Care</div>	\$250 & Coinsurance	Deductible	\$250, Deductible and Coinsurance
<div>Outpatient Surgery</div>	Coinsurance	Deductible	Deductible and Coinsurance
<div>Inpatient Hospital</div>	Coinsurance	Deductible	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		
<div>In-Network Individual Deductible</div>	\$0	\$4,500	\$4,500
<div>In-Network Family Deductible</div>	\$0	\$9,000	\$9,000
In-Network Individual Coinsurance Limit	\$1,750	\$0	40% to \$1,750
In-Network Family Coinsurance Limit	\$3,500	\$0	\$3,500
<div><div><div>In-Network Family Multiplier2</div><div>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.</div></div><div><div><div><div></div><div>Please have your provider swipe the Difference Card for the following amounts:</div><div><div>Medical &amp; Pharmacy</div><div>First \$4,500 Individual / \$9,000 Family</div></div><div>Call 888.343.2110 with any questions.</div></div></div><div><div>Mail Order Multiplier2</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>			