

UAH Plan Provision	PPO (Traditional)	High Deductible Health Plan (HDHP)*
	In-Network	In-Network
UAH Contribution to HSA (Individual/Family)	N/A	\$450 - Single \$900 - Family
Calendar Year Deductible* <i>Members pay this amount before receiving benefits from the plan.</i>	Medical - \$150 per person	Single - \$1,400 Family - \$2,800 Aggregate
Out-of-Pocket Maximum	\$2,500 - Single \$7,150 - Family Each for pharmacy and medical	\$3,500 - Single \$7,000 - Family All services combined including pharmacy and medical
Lifetime Maximum	Unlimited	
Preventive Care (Alabama Preventive Services)	Covered at 100%	
Primary Physician Office Visit	\$35 copay	Covered at 80%
Specialist Office Visit	\$55 copay	Covered at 80%
Outpatient X-Ray and Lab	\$125	Covered at 80%
Inpatient Hospital Services	\$400 copay then 100%	Covered at 80%
Outpatient Hospital Services	\$150 copay then 100%	Covered at 80%
Physical Therapy	80% limited to 30 visits	80% limited to 30 visits
Rehabilitative and Habilitative Occupational & Speech Therapy	80% limited to 30 visits	
Speech & Occupational Therapy for treatment of autism from birth- 18 yrs	Covered at 80% subject to deductible	Not covered
Telemedicine (Teladoc)	\$20	Covered at 80% (full cost \$55)
Emergency Room Care	\$150 copay	Covered at 80% Covered at 60% (non-emergency)
Prescription Drug Annual Deductible (Individual/Family)	Rx - \$150 per person (does not apply to generic drugs)	Included in Calendar Year Deductible of \$1,400 single and \$2,800 family (deductible applies to all drug types)
Retail Prescription Drugs Generic (Tier 1) Preferred Brand (Tier 2) Non-Preferred Brand (Tier 3) *** Specialty (Tier 4)	\$15 copay \$45 copay \$65 copay \$125 copay	Covered at 80%
Mail Order Prescription Drugs Generic (Tier 1) Preferred Brand (Tier 2) Non-Preferred Brand (Tier 3) ***	\$10 copay \$35 copay \$55 copay	Covered at 80%
Fertility Drugs	Covered	Not Covered

\* Deductible is the amount a member must pay before the plan begins paying for benefits.

\* All of the HDHP services except preventive services are subject to the calendar year deductible.

\*\*\*If a generic equivalent drug is available the employee will pay the cost difference between the generic drug and the brand drug plus the applicable copay.

*This is a summary only for comparative purposes of In-Network benefits. Always use an In-Network provider when utilizing services to maximize your plan benefits.*