UAH Plan Provision	PPO (Traditional) In-Network	High Deductible Health Plan (HDHP)* In-Network
UAH Contribution to HSA (Individual/Family)	N/A	**$500** - Single **$1,000** - Family
Calendar Year Deductible* *Members pay this amount before receiving benefits from the plan.*	Medical - $150 per person	Single - **$1,500** Family - **$3,000** 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 **35** visits	80% limited to **35** visits
Rehabilitative and Habilitative Occupational & Speech Therapy	80% limited to **35** 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 $1,500 single and $3,000 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.