United HealthCare 2026-2027

MEDICAL PLAN COMPARISON	EPO 1700		EPO 2000 Broad		2000 Kelsey		2000 Memorial Hermann		HSA3400		MEDICAL PLAN COMPARISON
ALVIN ISD 2026-2027 **UHC** This is a partial list of benefits. See separate Benefit Summary for each plan for more specific details	Plan pays for services from *PARTICIPATING* providers	Plan pays for services from *NONPARTICIPATING* providers	Plan pays for services from *PARTICIPATING* providers	Plan pays for services from *NONPARTICIPATING* providers	Plan pays for services from *PARTICIPATING* providers	Plan pays for services from *NONPARTICIPATING* providers	Plan pays for services from *PARTICIPATING* providers	Plan pays for services from *NONPARTICIPATING* providers	Plan pays for services from *PARTICIPATING* providers	Plan pays for services from *NONPARTICIPATING* providers	**ALVIN ISD 2026-2027** **UHC** This is a partial list of benefits. See separate Benefit Summary for each plan for more specific details
Preventative Care											**Preventative Care**
- Annual routine physical exam and routine child care	100%	N/A	100%	N/A	100%	N/A	100%	N/A	100%	N/A	- Annual routine physical exam and routine child care
- Routine lab and X-ray		N/A		N/A		N/A		N/A		N/A	- Routine lab and X-ray
Physician Services	Copay applies to first 4 combined visits:		Copay applies to first 4 combined visits:		Copay applies to first 4 combined visits:		Copay applies to first 4 combined visits:				**Physician Services**
- Primary Office Visits	$30		$45		$45		$45		80% after deductible	N/A	- Primary Office Visits
- Designated Specialist Visit	$45	N/A	$65	N/A	N/A	N/A	N/A	N/A			- Designated Specialist Visit
- Non-Designated Specialist Visit	$55		$75		$65		$65				- Non-Designated Specialist Visit
	After 4 combined visits, Ded. & Coinsurance apply		After 4 combined visits, Ded. & Coinsurance apply		After 4 combined visits, Ded. & Coinsurance apply		After 4 combined visits, Ded. & Coinsurance apply				
Hospital Services											**Hospital Services**
- Inpatient Care (facility)	80% after deductible	N/A	75% after deductible	N/A	80% after deductible	N/A	80% after deductible	N/A	80% after deductible	N/A	- Inpatient Care (facility)
- Inpatient Care (physician)	80% after deductible	N/A	75% after deductible	N/A	80% after deductible	N/A	80% after deductible	N/A	80% after deductible	N/A	- Inpatient Care (physician)
- Per Admission	$200 per day/5 max	N/A	$200 per day/5 max	N/A	$200 per day/5 max	N/A	$200 per day/5 max	N/A	80% after deductible	N/A	- Per Admission
- Preauthorization Penalty	None	N/A	None	N/A	None	N/A	None	N/A	None	N/A	Preauthorization Penalty
- Outpatient Surgery	80% after deductible	N/A	75% after deductible	N/A	80% after deductible	N/A	80% after deductible	N/A	80% after deductible	N/A	- Outpatient Surgery
- Emergency Room True Emergency only	$275 copay then Deductible and Coinsurance	$275 copay then Ded. and Coinsurance	$300 copay then Deductible and Coinsurance	$300 copay then Ded. and Coinsurance	$300 copay then Ded. and Coinsurance	$300 copay then Ded. and Coinsurance	$300 copay then Ded. and Coinsurance	$300 copay then Ded. and Coinsurance	80% after deductible	80% after deductible	- Emergency Room True Emergency only
- **U**rgent **C**are Visit	1 Visit: $75 copay all other visits, Ded. & Coinsurance	N/A	1 Visit: $85 copay all other visits, Ded. & Coinsurance	N/A	1 Visit: $85 copay all other visits, Ded. & Coinsurance	N/A	1 Visit: $85 copay all other visits, Ded. & Coinsurance	N/A	80% after deductible	N/A N/A	- **U**rgent **C**are Visit
- UC Diagnostic procedures	80% after deductible	N/A	75% after deductible	N/A	80% after deductible	N/A	80% after deductible	N/A	80% after deductible	N/A	- UC Diagnostic procedures
- UC surgical procedures	80% after deductible	N/A	75% after deductible	N/A	80% after deductible	N/A	80% after deductible	N/A	80% after deductible	N/A	- UC surgical procedures
Prescription Drugs											**Prescription Drugs**
- RX Coverage	80% after deductible	N/A	Copays apply to tier 2,3, and specialty after a $100 ind. Ded or a $300 family ded are met. $25/$55/$80/$255	N/A	100% after copay	N/A	100% after copay	N/A	80% after deductible	N/A	RX Coverage
- Copay	**Must satisfy deductible first**				$25/$55/$80/$255	N/A	$25/$55/$80/$255	N/A	**Must satisfy deductible first**		Copay
- Mail Order (3 mos. supply)	80% after deductible	N/A	Two times the retail copay for 90 day supply	N/A	Two times the retail copay for 90 day supply	N/A	Two times the retail copay for 90 day supply	N/A	80% after deductible	N/A	Mail Order (3 mos. supply)
Annual Deductibles *(per plan year)*											**Annual Deductibles** *(per plan year)*
- Individual	$1,700	N/A	$2,000	N/A	$2,000	N/A	$2,000	N/A	$3,400	N/A	- Individual
- Family	$5,100	N/A	$6,000	N/A	$6,000	N/A	$6,000	N/A	$6,800	N/A	- Family
Annual Out of Pocket Amt.											**Annual Out of Pocket Amt.**
- Individual - includes ded.	$7,500	N/A	$7,500	N/A	$7,000	N/A	$7,000	N/A	$7,250	N/A	- Individual - includes ded.
- Family - includes ded.	$14,600	N/A	$15,500	N/A	$14,800	N/A	$14,800	N/A	$14,500	N/A	- Family - includes ded.

This benefit comparison grid IS intended as a quick side by side comparison and NOT provided by UHC, benefits listed are non-binding. For full detailed information please see the Shedule of Benefits issued by UHC.

In network benefits shown utilize Memorial Hermann providers. Tier 2 benefits (not listed) utilize UHC Choice Plus providers. OON benefits not covered. See benefit detail for full description.