2026-27 UBC Rate Sheet

UNIVERSAL BENEFITS CONSORTIUM

The $5000 HMO Plan provides in-network coverage with predictable copays for primary care, specialist, and urgent care visits. Plan members also receive $0 virtual acute and behavioral telehealth care, 30% coinsurance after deductible for eligible services, and prescription coverage with tiered copays after the drug deductible is met.

$5000 HMO Plan

Monthly Premiums	<$30K Annually	<$30K and >$60K	>$60K Annually
Employee Only	$113.88	$273.88	$323.88
Employee + Spouse	$1,604.70	$1,764.70	$1,814.70
Employee + Child(ren)	$757.29	$917.29	$967.29
Family	$2,051.94	$2,211.94	$2,261.94

Plan Features	
Type of Coverage	In Network Only
Individual / Family Deductible	$5,000 / $10,000
Coinsurance	30%
Individual / Family Out-of-Pocket	$8,000 / $16,000

Doctor Visits	
Primary Care Physician Office Visit	$40 copay
Specialist Physician Office Visit	$75 copay
Recuro 24/7 Virtual Acute & Behavioral	$0

Immediate Care	
Urgent Care	$50
ER - Emergency Care	30% after deductible
ER - Non Emergency Care	Not Covered
Recuro 24& Virtual Acute & Behavioral	$0

Prescription Drugs	
Drug Deductible	$500 per person / $1,500 per family
Generic	$10 copay
Preferred Brand	$25 copay after deductible
Non-Preferred Brand	$50 copay after deductible
Specialty	30% to a max of $1,500 after deductible
Mail Order 2.5 Times Retail Copay	$25 / $62.50 / $125

BlueCross BlueShield

1-800-521-2227

help@ubc-benefits.com

Blue Essentials SM Network
Blue Essentials SM Plan
(HMO)

BlueCross BlueShield of Texas

Insured Benefit Highlights

Prepared For: Connally ISD
Effective Date: 9/1/2026

The following chart summarizes the coverage available under the offered HMO plan. All Covered Services (except in emergencies) must be provided by or through the Member's Participating Primary Care Physician/Practitioner (PCP), who may refer them for further treatment by Providers in the applicable network of Participating Specialists and Hospitals. Female Members may visit a Participating OB/GYN Physician in their PCP's Provider network for diagnosis and treatment without a Referral from their PCP. Urgent Care and Retail Health Clinics do not require Primary Care Physician/Practitioner Referral. This summary should be reviewed along with the Limitations and Exclusions.

IMPORTANT NOTE: Copayments and, if applicable, Coinsurance shown below indicate the amount you are required to pay, expressed as either a fixed dollar amount or a percentage of the Allowable Amount. Copayment and any applicable Coinsurance or Deductibles will be applied for each occurrence unless otherwise indicated. Copayments/Coinsurance, Deductibles and out-of-pocket maximums may be adjusted for various reasons as permitted by applicable law. Some services may require Preauthorization by HMO.

Deductible Per Plan Year

Per Individual Member	$ 5,000
Per Family	$ 10,000
Deductible credit from prior carrier (Applied on initial group enrollment only)	No
Common (One Deductible that applies to Inpatient Facility and Medical/Surgical Services)	

Out-of-Pocket Maximums Per Plan Year

Per Individual Member	$ 8,000
Per Family	$ 16,000
Credit for Out-of-Pocket Maximum from prior carrier (Applied on initial group enrollment only)	No
Deductible applies to Out-of-Pocket	Yes
Copayment applies to Out-of-Pocket	Yes

Professional Services

Primary Care Physician/Practitioner ("PCP") Office or Home Visit	$ 40 Copay
Participating Specialist Physician ("Specialist") Office or Home Visit	$ 75 Copay

Inpatient Hospital Services	
Inpatient Hospital Services, facility per admission	30% Coinsurance after Deductible
Outpatient Facility Services	
Outpatient Surgery	30% Coinsurance after Deductible
Radiation Therapy and Chemotherapy	30% Coinsurance after Deductible
Dialysis	30% Coinsurance after Deductible
Outpatient Laboratory and X-Ray Services	
Arteriograms, Computerized Tomography (CT Scan), Magnetic Resonance Imaging (MRI) Electroencephalogram (EEG), Myelogram, Positron Emission Tomography (PET Scan), per procedure	30% Coinsurance after Deductible
Other X-Ray Services	30% Coinsurance after Deductible
Outpatient Lab	30% Coinsurance after Deductible
Diagnostic Mammograms	
Diagnostic Mammograms are covered to the same extent as screening mammograms without member age limits as described in the **COVERED SERVICES AND BENEFITS; Health Maintenance and Preventive Services.**	No Copay
Rehabilitation Services	
Rehabilitation Services and Therapies, per visit	$ 40 Copay for PCP or $ 75 Copay for Specialist, 30% Coinsurance after Deductible for Inpatient Hospital Services or 30% Coinsurance after Deductible for Outpatient Facility Services, as applicable.
Maternity Care and Family Planning Services	
Maternity Care	
Prenatal and Postnatal Visit - Copay is applied to the first office visit only. Subsequent office visits are covered in full.	$ 40 Copay for PCP or $ 75 Copay for Specialist
Inpatient Hospital Services, for each admission	30% Coinsurance after Deductible
Family Planning Services:	
• Diagnostic counseling, consultations and planning services • Insertion or removal of intrauterine device (IUD), including cost of device • Diaphragm or cervical cap fitting, including cost of device • Insertion or removal of birth control device implanted under the skin, including cost of device • Injectable contraceptive drugs, including cost of drug	$ 40 Copay for PCP or $ 75 Copay for Specialist; unless otherwise covered under Contraceptive Services described in **Health Maintenance and Preventive Services.**
• Vasectomy	$ 40 Copay for PCP or $ 75 Copay for Specialist, or 30% Coinsurance after Deductible for Outpatient Surgery, as applicable.

Infertility Services	
Diagnostic counseling, consultations, planning and treatment services	$ 40 Copay for PCP or $ 75 Copay for Specialist
Artificial insemination, for each procedure and all services related to procedure (cost of sperm not covered)	$ 40 Copay for PCP or $ 75 Copay for Specialist, 30% Coinsurance after Deductible for Outpatient Surgery
In Vitro Fertilization, benefits paid same as any other pregnancy-related illness	Not Covered
Pregnancy Terminations, limited to Medically Necessary therapeutic terminations of pregnancy	$ 40 Copay for PCP or $ 75 Copay for Specialist, 30% Coinsurance after Deductible for Inpatient Hospital Services, or 30% Coinsurance after Deductible for Outpatient Surgery, as applicable.

Behavioral Health Services

Outpatient Mental Health Care	Same as PCP amount described in **Professional Services**.
Inpatient MIMental Health Care	Any charges described in **Inpatient Hospital Services** will apply.
State Mandated Additional Options-Delete row(s) that do not apply, delete this verbiage and unhighlight text. **Inpatient Mental Health Care** (IM5)	Deductible Applies Copay-Same as that required for other Inpatient Hospital Services. If the plan has no copayment for Inpatient Hospital Service, there is no copayment for inpatient mental health care services under this additional benefit option.
Serious Mental Illness	Benefits paid same as any other physical illness.
Chemical Dependency Services	Benefits paid same as any other Behavioral Health Service.

Emergency Services

Emergency Care	30% Coinsurance after Deductible, Copayment waived if admitted. (If admitted, any charges described in **Inpatient Hospital Services** will apply.)
Physician	30% Coinsurance after Deductible

Urgent Care Services

Urgent Care	$ 50 Copay Any additional charges as described in **Outpatient Laboratory and X-Ray Services** may also apply.

Retail Health Clinics	
Retail Health Clinics	PCP amount listed in **Professional Services**
Ambulance Services	
Ambulance Services	30% Coinsurance after Deductible
Extended Care Services	
Skilled Nursing Facility Services, for each day, up to 60 days per Calendar Year	30% Coinsurance after Deductible
Hospice Care, for each day	30% Coinsurance after Deductible; unless otherwise covered under **Inpatient Hospital Services**.
Home Health Care, per visit	30% Coinsurance after Deductible

Health Maintenance and Preventive Services	
Well child care through age 17	No Copay
Periodic health assessments for Members age 18 and older	No Copay
Immunizations • Childhood immunizations required by law for Members through age 6 • Immunizations for Members over age 6	 No Copay No Copay
Exam for prostate cancer, once every twelve months	No Copay
Bone mass measurement for osteoporosis	No Copay
Well-woman exam, once every twelve months, includes, but not limited to, exam for cervical cancer (Pap smear)	No Copay
Screening mammogram for female Members age 35 and over and for female Members with other risk factors, once every twelve months • Outpatient facility or imaging centers	No Copay No Copay
Contraceptive Services and Supplies • Contraceptive education, counseling and certain female FDA approved contraceptive methods, female sterilization procedures and devices • Tubal Ligation Breastfeeding Support, Counseling and Supplies • Electric breast pumps limited to one (1) per Calendar Year	 No Copay No Copay No Copay
Hearing Loss • Screening test from birth through 30 days • Follow-up care from birth through 24 months	 No Copay No Copay

Rectal screening for the detection of colorectal cancer for Members age 50 and older: • Annual fecal occult blood test, once every twelve months • Flexible sigmoidoscopy with hemoccult of the stool, limited to 1 every 5 years • Colonoscopy, limited to 1 every 10 years	 No Copay No Copay No Copay
Eye and ear screenings for Members through age 17, once every twelve months	$ 40Copay for PCP or $75 Copay for Specialist
Eye and ear screening for Members age 18 and older, once every two years	$40 Copay for PCP or $ 75 Copay for Specialist
Early detection test for cardiovascular disease, limited to 1 every 5 years. • Computer tomography (CT) scanning • Ultrasonography	 30% Coinsurance after Deductible 30% Coinsurance after Deductible
Early detection test ovarian cancer (CA125 blood test), once every twelve months	$40 Copay for PCP or $75 Copay for Specialist

Dental Surgical Procedures	
Dental Surgical Procedures (limited Covered Services)	$40 Copay for PCP or $75 Copay for Specialist, 30% Coinsurance after Deductible for Inpatient Hospital Services, or 30% Coinsurance after Deductible for Outpatient Surgery, as applicable.
Cosmetic, Reconstructive or Plastic Surgery	
Cosmetic, Reconstructive or Plastic Surgery (limited Covered Services)	$40 Copay for PCP or $75 Copay for Specialist, 30% Coinsurance after Deductible for Inpatient Hospital Services, or 30% Coinsurance after Deductible for Outpatient Surgery, as applicable.
Allergy Care	
Testing and Evaluation	30% Coinsurance after Deductible
Injections	30% Coinsurance after Deductible
Serum	30% Coinsurance after Deductible
Diabetes Care	
Diabetes Self-Management Training, for each visit	$40 Copay for PCP or $75 Copay for Specialist
Diabetes Equipment	30% Coinsurance after Deductible
Diabetes Supplies Some Diabetes Supplies are only available utilizing pharmacy benefits, through a Participating Pharmacy. You must pay the applicable **PHARMACY BENEFITS** amount shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any applicable pricing differences.	30% Coinsurance after Deductible

Prosthetic Appliances and Orthotic Devices	
Prosthetic Appliances and Orthotic Devices $300 maximum benefit for purchase of one (1) wig needed as a result of current chemotherapy or radiation treatment for cancer.	30% Coinsurance after Deductible
Cochlear Implants Limit one (1) per impaired ear, with replacements as Medically Necessary or audiologically necessary.	30% Coinsurance after Deductible. Any additional charges as described in **Outpatient Surgery** may also apply.
Hearing Aids	
Hearing Aids Maximum benefit - one per ear, every 36 months	30% Coinsurance after Deductible

Durable Medical Equipment	
Choose one and delete the other row **Durable Medical Equipment**	30% Coinsurance after Deductible
Durable Medical Equipment (DM8) Rental or purchase of DME (initial placement only, and standard replacements because of physical growth of members under age 18)	General Payment Level; Deductible Applies
Speech and Hearing Services	
SH1 – Speech and Hearing Inpatient and Outpatient necessary care and treatment for loss or impairment of speech and hearing; hearing aids **not** covered under this mandated benefit offer.	Deductible Applies *Yes*

Pharmacy Benefits		
Prescription Drug Benefits (Prime Therapeutics)		
Drug List**	Performance	
Drug Network	Broad Advantage	
Prescription Drug Out-of-Pocket Maximum	All benefits, including prescription drug benefits (retail and mail service) apply to the Out-of-Pocket Maximum shown on page 1.	
Prescription Drug Deductible***	Separate Prescription Drug Deductible applies to Retail & Mail Service Pharmacy: Individual: $500 / Family: $1500 Deductible will apply to the Out-of-Pocket Maximum.	
Participating Pharmacy Retail Pharmacy One Copayment amount per 30-day supply, up to a 90-day supply only Extended Supply (if allowed by the Prescription Order) – one Copayment amount per 30-day supply, up to a 90-day supply.	Generic Drug Preferred Brand Name Drug Non-Preferred Brand Name Drug	$10 Copay $25 Copay after Deductible $50 Copay after Deductible
Mail-Order Program One Copayment amount per 90-day supply, up to a 90-day supply only	Generic Drug Preferred Brand Name Drug Non-Preferred Brand Name Drug	$25 Copay $62.50 Copay after Deductible $125 Copay after Deductible
Specialty Pharmacy Program One Copayment amount per 30-day supply, up to a 30-day supply only	Specialty Drug	30% to a Max of $1,500 Copay after Deductible
Affordable Care Act (ACA) Preventive (including Vaccinations Obtained Through Pharmacies):	The group accepts all ACA Preventive categories (not optional for Non-Grandfathered)	

**The drug lists are available at: bcbstx.com/member/rx_drugs.html

*** Three-month Deductible carryover does not apply to prescription drug deductible.

For additional information regarding the applicable Drug List/Preferred Drug List, please call customer service or visit the website at http://www.bcbstx.com/members/rx_drugs.html