2027 UBC Rate Sheet

UNIVERSAL BENEFITS CONSORTIUM

ECISD

Wellness Benefits at No Extra Cost

- **Free Preventative Care**
- **Free Recuro 24/7 Virtual Acute & Behavioral Visits**
- **Free Generic Drugs Available**

Additional Services

CareATC Health & Wellness Clinic

- **Free or Low Cost Acute and Chronic condition management**
- **Convenient location with 24/7 scheduling availability**
- **Wellness Clinic Doctors can serve as your PCP for the BCBS HMO plans**
- **New extended hours beginning January 1st:**
  M-F 7am-7pm, Sat 10am-4pm

Plan Summary

	Option III HSA	Option II HMO	Option I HMO
	• Lowest Premiums • Nationwide Network • No PCP referrals • Free Preventative Generic Drugs • Compatible with a Health Savings Account (HSA)	• Mid Deductibles and Out-of-Pocket Maximums • HMO Network • PCP referrals are required • Free Generic Drugs	• Lowest Deductibles and Out-of-Pocket Maximums • Copays for doctor visits • HMO Network • PCP referrals are required • Free Generic Drugs
Monthly Premiums			
Employee Only	$30	$135	$225
Employee & Spouse	$820	$830	$1,030
Employee & Child / Children	$460 / $530	$540 / $720	$665 / $760
Employee & Family	$1,020	$1,145	$1,395
Plan Features			
Type of Coverage	In Network Only	HMO Network Only	HMO Network Only
Individual / Family Deductible	$3,250 / $6,500	$3,250 / $6,500	$2,165 / $4,330
Coinsurance	30% after Deductible	30% after Deductible	30% after Deductible
Individual / Family Maximum Out-of-Pocket	$6,000 / $12,000	$6,000 / $12,000	$6,000 / $12,000
Doctor Visits			
Primary Care	30% after Deductible	30% after Deductible	$60 Copay
Specialist	30% after Deductible	30% after Deductible	$100 Copay
Recuro 24/7 Virtual Acute & Behavioral	$0	$0	$0
Immediate Care			
Urgent Care	30% after Deductible	30% after Deductible	$60 Copay
ER - Emergency Care	$200 Copay + 30% after Deductible	$200 Copay + 30% after Deductible	$200 Copay + 30% after Deductible
ER - Non Emergency Care	Not Covered	Not Covered	Not Covered
Recuro 24/7 Virtual Acute & Behavioral	$0	$0	$0
Prescription Drugs			
Drug Deductible	$1,500 Individual / $3,000 Family	$400 per Person (Brand / Specialty Only)	$400 per Person (Brand / Specialty Only)
Generics (30 Day Supply / 90 Day Supply)	$0 after Deductible	$0 (Deductible Waived)	$0 (Deductible Waived)
Preferred Brand	30% after Deductible	$100 / $200 (30/90-day) (after Deductible)	$100 / $200 (30/90-day) (after Deductible)
Non-Preferred Brand	30% after Deductible	$175 / $350 (30/90-day) (after Deductible)	$175 / $350 (30/90-day) (after Deductible)
Specialty	30% after Deductible	Lesser of $1,500 or 25% after Deductible	Lesser of $1,500 or 25% after Deductible
Out-of-Pocket Maximum	$1,650 Individual / $3,300 Family	$1,350 Individual / $2,700 Family	$1,350 Individual / $2,700 Family