ERS®
EMPLOYEES RETIREMENT SYSTEM OF TEXAS

# HEALTH PLANS COMPARISON CHART
## EMPLOYEES AND RETIREES NOT ELIGIBLE FOR MEDICARE
### EFFECTIVE SEPTEMBER 1, 2021

This chart shows your share of costs for commonly used medical, mental health, prescription drug and diabetes supply benefits in the HealthSelect of Texas® and Consumer Directed HealthSelect℠ plans. For in-depth information about eligibility, services that are covered and not covered, and how benefits are paid, view the Master Benefits Plan Document (MBPD) on your plan's website. If there is a conflict between the MBPD, MBPD Amendments and this chart, the MBPD and its Amendments will control.

Blue Cross and Blue Shield of Texas (BCBSTX) administers medical and mental health benefits in both plans. OptumRx, an affiliate of UnitedHealthcare, manages prescription drug benefits for the plans. As administrators, they process claims and oversee the provider networks and drug formularies. ERS designs the benefits and pays the claims.

| | HealthSelect of Texas | | Consumer Directed HealthSelect | |
|---|---|---|---|---|
| | **HealthSelect of Texas® and HealthSelect℠ Out-of-State In-Network** | **HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network** | **Consumer Directed HealthSelect℠ High-deductible Health Plan In-Network** | **Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network** |
| **Administrator** | **Blue Cross and Blue Shield of Texas (BCBSTX)** | | | |
| **Annual deductible** | None | $500 per individual<br>$1,500 per family | $2,100 per individual,<br>$4,200 per family<br>To help cover part of the deductible, the State contibutes to an eligible member's health savings account:<br>$540/year for an individual,<br>$1,080/year for a family. | $4,200 per individual,<br>$8,400 per family<br>To help cover part of the deductible, the State contibutes to an eligible member's health savings account:<br>$540/year for an individual,<br>$1,080/year for a family. |
| **Out-of-network benefits?** | | Yes. See next page for details. | | Yes. See next page for details. |
| **Balance billing?** (Balance billing is when an out-of-network provider charges you the difference between their billed charges and the plan's allowed amount.) | | Yes. Balance billing may apply to certain out-of-network services. For more information, see the plan's Master Benefit Plan Document. | | Yes. Balance billing may apply to certain out-network services. For more information, see the plan's Master Benefit Plan Document. |
| **Total in-network out-of-pocket maximum** (including deductibles, coinsurance and copays)[1] | Through 12/31/21:<br>$6,750 per person;<br>$13,500 per family<br>1/1/22 – 12/31/22:<br>$7,000 per person;<br>$14,000 per family | | Through 12/31/21:<br>$6,750 per person;<br>$13,500 per family<br>1/1/22 – 12/31/22:<br>$7,000 per person;<br>$14,000 per family | |
| **Out-of-pocket coinsurance maximum** | $2,000 per person | $7,000 per person | None | None |
| **Inpatient copay maximum** | $750 copay max, up to 5 days per hospital stay<br>$2,250 copay max per calendar year per person | | None | None |
| **Primary care provider (PCP) required?** | Yes for participants who live and work in Texas; no for out-of-state participants | No | No | No |
| **Referrals required?** | Yes for participants who live and work in Texas; no for out-of-state participants | No | No | No |

[1]Includes medical and prescription drug copays, coinsurance and deductibles. Excludes non-network and bariatric services.

# Medical Benefits

| Service | HealthSelect of Texas® and HealthSelect℠ Out-of-State In-Network | HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network | Consumer Directed HealthSelect℠ High-deductible Health Plan In-Network | Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network |
|---|---|---|---|---|
| **Allergy treatment** | Covered at 100% if administered in a physician's office; 20% coinsurance in any other outpatient location | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Ambulance services** (for emergencies) | 20% coinsurance | 20% coinsurance; annual deductible does not apply | 20% coinsurance after annual deductible is met | 20% coinsurance after annual in-network deductible is met |
| **Bariatric surgery**[2] | • Deductible: $5,000<br>• Coinsurance: 20%<br>• Lifetime max: $13,000 | Not covered | Not covered | Not covered |
| **Chiropractic care** | • Without office visit: 20% coinsurance<br>• With office visit: $40 copay plus 20% coninsurance<br>• Maximum benefits of $75 per visit and maximum of 30 visits per calendar year | 40% coinsurance after annual deductible is met.<br>Maximum benefits of $75 per visit and maximum of 30 visits per calendar year | 20% coinsurance after annual deductible is met.<br>Maximum benefits of $75 per visit and maximum of 30 visits per calendar year | 40% coinsurance after annual deductible is met.<br>Maximum benefits of $75 per visit and maximum of 30 visits per calendar year |
| **Diabetes equipment**[2] | 20% coinsurance; see page 6 for details. | 40% coinsurance after annual deductible is met; see page 6 for details. | 20% coinsurance after annual deductible is met; see page 6 for details. | 40% coinsurance after annual deductible is met; see page 6 for details. |
| **Diabetes supplies** | See page 6 for details. | | | |
| **Diagnostic X-rays and lab tests** | 20% coinsurance | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Diagnostic mammography** | Covered at 100% | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Durable medical equipment**[2] | 20% coinsurance | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Facility-based providers** (radiologists, pathologists and labs, anesthesiologists, emergency room physicians etc.) | 20% coinsurance | Emergencies: 20% coinsurance; annual deductible does not apply.<br>Non-emergencies: 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | Emergencies: 20% coinsurance after annual in-network deductible is met.<br>Non-emergencies: 40% coinsurance after annual out-of-network deductible is met. |
| **Facility emergency care** (non-FSER) and hospital-affiliated freestanding emergency departments | $150 copay plus 20% coinsurance<br>(If admitted, copay will apply to hospital copay.) | Emergencies: $150 copay plus 20% coinsurance (If admitted, copay will apply to hospital copay.) Annual deductible does not apply.<br>Non-emergencies: $150 copay plus 40% coinsurance after annual out-of-network deductible is met. | 20% coinsurance after annual deductible is met | Emergencies: 20% coinsurance after annual in-network deductible is met.<br>Non-emergencies: 40% coinsurance after annual out-of-network deductible is met. |
| **Freestanding emergency room facility** | $150 copay plus 20% coinsurance | Emergencies: $300 copay plus 20% coinsurance; annual deductible does not apply.<br>Non-emergencies: $300 copay plus 40% coinsurance after annual out-of-network deductible is met. | 20% coinsurance after annual deductible is met | Emergencies: 20% coinsurance after annual in-network deductible is met.<br>Non-emergencies: 40% coinsurance after annual out-of-network deductible is met. |
| **Habilitation and rehabilitation services - outpatient therapy** (including physical therapy, occupational therapy and speech therapy) | 20% coinsurance | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |

[2]Preauthorization may be required.

| Service | HealthSelect of Texas® and HealthSelect[SM] Out-of-State In-Network | HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network | Consumer Directed HealthSelect[SM] High-deductible Health Plan In-Network | Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network |
|---|---|---|---|---|
| **Hearing aids** (for covered participants over age 18) | Plan pays up to $1,000 per ear every three years. In-network and out-of-network hearing aids are covered at the same benefit level. | | Plan pays up to $1,000 per ear every three years after deductible is met. | |
| **Hearing aids** (for participants age 18 and under) | Plan pays 100%, limit of one hearing aid per ear every three years. In-network and out-of-network hearing aids are covered at the same benefit level. | | 20% coinsurance after annual in-network deductible is met. In-network and out-of-network hearing aids are covered at the same benefit level. | |
| **High-tech radiology** (CT scan, MRI and nuclear medicine)[2] | $100 copay plus 20% coinsurance | $100 copay plus 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Home health care**[2] | 20% coinsurance | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Hospice care**[2] | 20% coinsurance | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Inpatient hospital facility** (semi-private room and day's board, and intensive care unit)[2] | • $150/day copay plus 20% coinsurance<br>• $750 copay max, up to 5 days per hospital stay<br>• $2,250 copay max per calendar year per person | • $150/day copay plus 40% coinsurance after annual deductible is met.<br>• $750 copay max, up to 5 days per hospital stay<br>• $2,250 copay max per calendar year per person | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Maternity care doctor charges only; inpatient hospital copays will apply** | $25 or $40 for first pre-natal visit; no charge for routine post natal appointments | 40% coinsurance after annual deductible is met | No charge for routine prenatal appointments and 20% coinsurance for first post-natal visit after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Medications and injections administered by a provider** (see below for outpatient medications and injections)[2] | • Physician's office: Covered at 100% after copay (or 100% if no charge is assessed for office visit)<br>• Any other outpatient location: 20% coinsurance.<br>• Preventive vaccines covered at 100% | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met<br>Preventive vaccines covered at 100% | 40% coinsurance after annual deductible is met |
| **Office surgery and diagnostic procedures** | 20% coinsurance | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **PCP office visit** | $25 copay | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Private duty nursing**[2] | 20% coinsurance | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Retail health/ convenience care clinic** | $25 copay | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Routine eye exam, one per year per participant** | $40 copay | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Routine preventive care** | No cost to participant(s) | 40% coinsurance after annual deductible is met | No cost to participant(s) | 40% coinsurance after annual deductible is met |
| **Skilled nursing facility/inpatient rehabilitation facility services**[2] | 20% coinsurance | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Specialist physician office visit** | $40 copay with valid PCP referral on file | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Surgery (outpatient) other than in physician's office**[2] | $100 copay plus 20% coinsurance | $100 copay plus 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |

[2]Preauthorization may be required.

| Service | HealthSelect of Texas® and HealthSelect℠ Out-of-State In-Network | HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network | Consumer Directed HealthSelect℠ High-deductible Health Plan In-Network | Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network |
|---|---|---|---|---|
| **Telemedicine visit** | Coverage is based on place of treatment billed.<br>• Physican's office: $25/$40 copay for physician's office visit<br>• Any other outpatient telemedicine: 20% coinsurance | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Therapeutic treatments - outpatient** | 20% coinsurance | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Urgent care clinic** | $50 copay plus 20% coinsurance | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Virtual visits/e-visits** (medical) | $0 copay for virtual visits when provided by Doctor on Demand or MDLive | Not covered | 20% coinsurance after annual deductible is met if Doctor on Demand or MDLive is used | Not covered |

[2]Preauthorization may be required.

# Mental Health/Behavioral Health/Substance Abuse Benefits

Benefits apply to all covered mental health/behavioral health/substance abuse services (including serious mental illness treatment, substance abuse treatment, autism spectrum disorder services, etc.).

| | HealthSelect of Texas® and HealthSelect℠ Out-of-State In-Network | HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network | Consumer Directed HealthSelect℠ High-deductible Health Plan In-Network | Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network |
|---|---|---|---|---|
| **Inpatient hospital mental health stay**[2] | • $150/day copay plus 20% coinsurance<br>• $750 copay max, up to 5 days per hospital stay<br>• $2,250 copay max per calendar year per person | • $150/day copay plus 40% coinsurance after annual deductible is met<br>• $750 copay max, up to 5 days per hospital stay<br>• $2,250 copay max per calendar year per person | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Mental health telemedicine** | Coverage is based on place of treatment: $25 copay for mental health office visit; 20% coinsurance for any other outpatient telemedicine. | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Outpatient facility care** (partial hospitalization/ day treatment and extensive outpatient treatment)[2] | 20% coinsurance | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Outpatient physician or mental health provider office visit** | $25 copay | 40% coinsurance after annual deductible is met | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Virtual visits/e-visits** (mental health) | $0 copay for virtual visits when provided by Doctor on Demand or MDLive | Not covered | 20% coinsurance after annual deductible is met | Not covered |

[2]Preauthorization may be required.

*All Texas Employees Group Benefits Program (GBP) benefits could change without notice. The Texas Legislature decides the level of funding for such benefits and has no continuing obligation to provide those benefits beyond each fiscal year.*

# Prescription Drug Benefits

The cost share you pay for your medication depends on its drug tier, the quantity your purchase (30-, 60- or 90-day supply) and whether the prescription is filled at a retail pharmacy (network or non-network), Extended Day Supply Pharmacy (EDS) or mail service pharmacy.

You will pay less for your drugs when you fill your prescription at a network pharmacy. The OptumRx network includes thousands of retail locations, including national chains and many community pharmacies. To find a network pharmacy near you, use the Find a Network Pharmacy tool at **www.HealthSelectRx.com** or call an OptumRx customer care representative toll-free at (855) 828-9834 (TTY 711).

Non-maintenance medications are those prescribed for temporary use or for short-term conditions. Maintenance medications are those taken more regularly for long-term conditions.

| | HealthSelect of Texas® and HealthSelect℠ Out-of-State In-Network | HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network | Consumer Directed HealthSelect℠ High-deductible Health Plan In-Network | Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network |
|---|---|---|---|---|
| **Pharmacy benefits manager (PBM)** | OptumRx (UnitedHealthcare) | | | |
| **Out-of-network benefits?** | | Yes | | Yes |
| **Deductible** | $50 prescription drug deductible per participant per calendar year applies before the plan pays for any prescription drugs (except covered preventive medications, specific diabetic supplies (as listed on page 6) and insulin dispensed by an in-network pharmacy) | | $2,100 per individual;<br>$4,200 per family<br>Medical and prescription drug expenses apply to the deductible. | $4,200 per individual;<br>$8,400 per family<br>Medical and prescription drug expenses apply to the deductible. |
| **Tier 1** (mostly generic drugs) | Non-maintenance and maintenance: $10 copay<br>Mail order or extended day supply pharmacy (90 days' supply): $30 copay | Non-maintenance and maintenance:<br>$10 copay plus 40% coinsurance<br>Mail order or extended day supply pharmacy (90 days' supply): $30 copay plus 40% coinsurance | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Tier 2** (mostly preferred brand name drugs)[2] | • Non-maintenance: $35 copay<br>• Maintenance: $45 copay<br>• Mail order or extended day supply pharmacy: $105 copay | • Non-maintenance: $35 copay plus 40% coinsurance<br>• Maintenance: $45 copay plus 40% coinsurance<br>• Mail order or extended day supply: $105 copay plus 40% coinsurance | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Tier 3** (mostly non-preferred brand name drugs)[2] | • Non-maintenance: $60 copay<br>• Maintenance: $75 copay<br>• Mail order or extended day supply pharmacy: $180 copay | • Non-maintenance: $60 copay plus 40% coinsurance<br>• Maintenance: $75 copay plus 40% coinsurance<br>• Mail order or extended day supply pharmacy: $180 copay plus 40% coinsurance | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |
| **Specialty drugs**[2] | If purchased through a pharmacy, specialty drugs are covered at the specific tier level (generic, preferred or non-preferred) as listed above. Otherwise, they are covered as a medical benefit. | | 20% coinsurance after annual deductible is met | 40% coinsurance after annual deductible is met |

[2]Preauthorization may be required.

# Diabetes Equipment and Supplies

Other diabetes equipment, supplies, and prescription drugs not listed below may be covered under these plans. For more information about your prescription drug benefits or for help finding an in-network pharmacy, contact HealthSelect PDP customer care toll-free at (855) 828-9834 (TTY:711). For more information on your medical plan benefits, contact a BCBSTX Personal Health Assistant toll-free at (800) 252-8039 (TTY: 711).

| | HealthSelect of Texas and HealthSelect Out-of-State | | Consumer Directed HealthSelect | |
|---|---|---|---|---|
| | Prescription Drug Program (PDP) benefits | Medical plan benefits | Prescription Drug Program (PDP) benefits | Medical plan benefits |
| **Diabetes glucometers** | OneTouch Ultra, OneTouch Verio, OneTouch Verio Flex, or OneTouch Verio Reflect Meter* brands of diabetes glucometers are covered at **no cost** to participants when received through LifeScan's free glucometer program. For more information on the free glucometer program, call OptumRx.<br>Other brands of diabetes glucometers covered under the PDP apply either a Tier 2 or Tier 3 copay when purchased from a PDP in-network pharmacy. | 20% coinsurance when purchased from a BCBSTX in-network provider<br>40% coinsurance after annual out-of-network deductible is met when purchased from a BCBSTX out-of-network provider | OneTouch Ultra, OneTouch Verio, OneTouch Verio Flex, or OneTouch Verio Reflect Meter* brands of diabetes glucometers are covered at **no cost** to participants when received through LifeScan's free glucometer program. For more information on the free glucometer program, call OptumRx.<br>Other brands of diabetes glucometers covered under the PDP apply 20% coinsurance after annual in-network deductible is met when purchased from a PDP in-network pharmacy. | 20% coinsurance after annual in-network deductible is met when purchased from a BCBSTX in-network provider<br>40% coinsurance after annual out-of-network deductible is met when purchased from a BCBSTX out-of-network provider |
| **Diabetic supplies** | OneTouch Ultra, OneTouch Verio, OneTouch Verio Flex, or OneTouch Verio Reflect* diabetic test strips are covered at **no cost** to participants when purchased from a PDP in-network pharmacy. Lancets, lancing devices, and syringes are covered at no cost to participants when purchased from a PDP in-network pharmacy.<br>Other covered diabetic supplies covered under the PDP apply either a Tier 1, Tier 2, or Tier 3 copay when purchased from a PDP in-network pharmacy. | 20% coinsurance for in-network and out-of-network covered diabetic supplies. Annual deductible does not apply.<br>40% coinsurance after annual out-of-network deductible is met when purchased from a BCBSTX out-of-network provider | 20% coinsurance for covered diabetic supplies after annual in-network deductible is met when purchased from a PDP in-network pharmacy.<br>40% coinsurance after annual out-of-network deductible is met when purchased from a PDP out-of-network pharmacy. | 20% coinsurance for in-network and out-of-network covered diabetic supplies. Annual deductible does not apply.<br>40% coinsurance after annual out-of-network deductible is met when purchased from a BCBSTX out-of-network provider. |
| **Prescription insulin** | In-network pharmacy: Insulin products on the PDP drug list (formulary) are covered at a Tier 1, Tier 2 or Tier 3 copay. The annual prescription drug deductible does not apply to these products beginning 9/1/21.<br>Out-of-network pharmacy: Insulin products are covered at a Tier 1, Tier 2 or Tier 3 copay and 40% coinsurance. | Not covered under medical plan benefits | In-network pharmacy: 20% coinsurance for insulin products on the PDP drug list (formulary). The annual prescription drug deductible does not apply to these products beginning 9/1/21.<br>Out-of-network pharmacy: 40% coinsurance for insulin products after annual out-of-network deductible is met. | Not covered under medical plan benefits |

*Benefits and covered brands of glucometers and test strips are subject to change.