

The plan year for HealthSelect MA PPO and KelseyCare Advantage MA HMO is January 1 to December 31. The plan year for the other plans is September 1 to August 31. This chart is intended to provide a general comparison of GBP benefits and is subject to change.

Benefit	Original Medicare <sup>4</sup> (Medicare rates are subject to change)	HealthSelect MA PPO (No coordination with Medicare is necessary)	Medicare Primary, HealthSelect Secondary (HealthSelect and Medicare coordinate benefits for you)	Medicare Primary, GBP HMO Secondary (GBP HMO plans coordinate benefits with Medicare for you)		KelseyCare Advantage MA HMO (No coordination with Medicare is necessary)
				Community First, Scott and White	KelseyCare powered by Community Health Choice	
<b>Calendar year deductible</b>	\$183	None	\$200 per individual \$600 per family	None	None	None
<b>Office visits in conjunction with an illness or injury</b>	20%	\$0	\$0 copay / 30% <sup>4,7</sup> coinsurance	\$0 copay / \$25 <sup>7</sup> copay	\$0 copay / \$15 <sup>7</sup> copay	\$0
<b>Specialty physician office visit</b>	20%	\$0	\$0 copay / 30% <sup>4,7</sup> coinsurance	\$0 copay / \$40 <sup>7</sup> copay	\$0 copay / \$25 <sup>7</sup> copay	\$0
<b>Diagnostic tests and x-rays, including allergy testing</b>	20%	\$0	\$0 copay / 30% <sup>4,7</sup> coinsurance	\$0 copay / 20% <sup>7</sup> coinsurance	\$0 copay for diagnostic tests / x-rays. Allergy testing: \$15 PCP or \$25 specialist copay <sup>6,7</sup>	\$0
<b>Diagnostic mammography</b>	20%	\$0	\$0 copay / 30% <sup>4,7</sup> coinsurance	\$0 copay / 20% <sup>7</sup> coinsurance	\$0 copay <sup>7</sup>	\$0
<b>Diagnostic lab services</b>	\$0	\$0	\$0 copay / 30% <sup>4,7</sup> coinsurance	\$0 copay / 20% <sup>7</sup> coinsurance	\$0 copay <sup>7</sup>	\$0
<b>Preventive services*</b> (such as screening mammogram, physical, well woman exam, prostate cancer screening, etc.)	\$0 <sup>1,3</sup> Does not cover lab tests	\$0 <sup>1,3</sup> Covers screening lab tests	\$0*	\$0 <sup>1</sup>	\$0 <sup>1</sup>	\$0 <sup>1,3</sup>
<b>Mental health and substance use disorder</b>						
<b>a. Outpatient physician or mental health provider office visits</b>	20%	\$0	\$0 copay / 30% <sup>4,7</sup> coinsurance	\$25	\$25	\$0
<b>b. Hospital—Inpatient stay</b> (semi-private room and days board, and intensive care unit)	\$0 <sup>5</sup> after the following amounts for each benefit period: \$1,316 deductible for days 1-60 \$329 copay per day (days 61-90) \$658 copay per lifetime reserve day (days 91-150)	\$0 per admission	\$0 <sup>8</sup> If provider doesn't accept Part A, then coverage is \$150 copay/day up to \$750 per admission and \$2,250 per Calendar Year. 30% <sup>4,7</sup> after copay	\$0 copay / 30% insurance	20% coinsurance (plus \$150 a day copay per admission)	\$0
<b>c. Outpatient facility care</b> (partial hospitalization/ day treatment and extensive outpatient treatment)	20%	\$0	\$0 copay / 30% <sup>4,7</sup> coinsurance	Community First: \$25 copay (prior authorization required) Scott&White: \$25 copay (covered as any other illness)	\$25 copay	\$0
<b>Office surgery and diagnostic procedures</b>	20%	\$0	\$0 copay / 30% <sup>4,7</sup> coinsurance	Community First: 20% coinsurance <sup>7</sup> Scott&White: \$100 copay / 20% coinsurance	\$0 / \$15 PCP or \$25 specialist copay <sup>6,7</sup>	\$0
<b>Immunizations*</b>	\$0	\$0	\$0	\$0	\$0	\$0
<b>High-tech radiology</b> (CT scan, MRI, nuclear medicine)	20%	\$0	\$0 copay / 30% insurance	\$0 copay / \$100 <sup>7</sup> copay plus 20% coinsurance	\$150 <sup>7</sup> copay/scan type/ day	\$0
<b>Allergy injections and serum</b>	20%	\$0	\$0 copay / 30% <sup>4,7</sup> coinsurance	\$0 copay / 20% <sup>7</sup> coinsurance	Allergy Serum: \$0 Without office visit: \$0 With office visit: \$15 PCP or \$25 specialist copay <sup>6,7</sup>	\$0

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				Community First, Scott and White	KelseyCare powered by Community Health Choice	
<b>Routine eye exam</b>	Does not cover	\$0 <sup>1</sup>	30% <sup>1,4</sup> coinsurance	\$40 copay <sup>2</sup>	\$25 copay <sup>2</sup>	\$0 <sup>1</sup>
<b>Vision</b> (Contact lens fitting exams are not covered)	Frames: You pay 100% for non-covered services 20% for one pair of eyeglasses after each cataract surgery with an intraocular lens.	\$0 for one pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens.	Frames: Does not cover	Community First: Does not cover Scott & White: Does not cover	Does not cover	\$150 plan coverage limit for eyewear, glasses, and/or contact lenses every two years unrelated to post-cataract surgery. <sup>10</sup> Allowance can only be used on date of service.
	Contacts: You pay 100% for non-covered services 20% for one set of contact lenses after each cataract surgery with an intraocular lens.	\$0 for one pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens.	Contacts: Does not cover	Community First: You receive a \$125 allowance every 2 years in lieu of glasses <sup>9</sup> Scott & White: Does not cover	Does not cover	
<b>Routine hearing test</b>	Does not cover	Does not cover	30% <sup>4</sup> coinsurance	Without office visit: 20% coinsurance, With office visit: \$40 copay plus 20% coinsurance	Without office visit: \$0 copay / 20% <sup>7</sup> coinsurance With office visit: \$0 copay / \$25 copay <sup>7</sup> plus 20% coinsurance	\$0 copay for up to one supplemental routine hearing exam every year <sup>1,2</sup>
<b>Diagnostic speech and hearing testing</b>	20%	\$0	\$0 copay / 30% <sup>4,7</sup> coinsurance	Without office visit: \$0 copay / 20% <sup>7</sup> coinsurance With office visit: \$0 copay / \$40 copay <sup>7</sup> plus 20% coinsurance	Without office visit: \$0 copay / 20% <sup>7</sup> coinsurance With office visit: \$0 copay / \$25 copay <sup>7</sup> plus 20% coinsurance	\$0 for Medicare-covered diagnostic hearing exams
<b>Speech and hearing therapy</b>	20%	\$0	\$0 copay / 30% <sup>4,7</sup> coinsurance	Without office visit: \$0 copay / 20% <sup>7</sup> coinsurance With office visit: \$0 copay / \$40 copay <sup>7</sup> plus 20% coinsurance	Without office visit: \$0 copay / 20% <sup>7</sup> coinsurance With office visit: \$0 copay / \$25 copay <sup>7</sup> plus 20% coinsurance	\$0
<b>Hearing aids</b>	Does not cover	\$1,000 benefit allowance per ear every 3 years	\$1,000 benefit allowance per ear every 3 years	\$1,000 benefit allowance per ear every 3 years (Repairs not covered)	\$1,000 benefit allowance per ear every 3 years (Repairs not covered)	\$1,500 plan coverage limit for hearing aids every 2 years (Does not include battery replacement) \$0 copayment for up to one hearing aid fitting/evaluation every 2 years <sup>2</sup>
<b>Chiropractic care</b>	20% for Medicare-covered chiropractic services	30% for specialist office visit for routine services, up to a maximum of a \$75 benefit per visit. Benefit is limited to 30 visits per plan year. \$0 Medicare-covered chiropractic services.	\$0 copay / 30% <sup>4,7</sup> coinsurance	Community First: \$0 copay / \$40 copay <sup>7</sup> Benefit is limited to 30 visits per plan year. Scott & White: Without office visit: 20% <sup>7</sup> ; with office visit: \$40 plus 20% <sup>7</sup> . Benefit is limited to 35 visits per calendar year; 5 per month	\$0 copay / \$25 copay <sup>7</sup> Benefit is limited to 30 visits per calendar year.	\$0 for each Medicare-covered visit
<b>Urgent care clinic</b>	20%	\$0	\$0 copay / 30% <sup>4,7</sup> coinsurance	\$0 copay / \$50 copay <sup>7</sup> + 20% coinsurance	\$0 copay / \$50 copay <sup>7</sup> + 20% coinsurance	\$0
<b>Emergency room care</b>	20% Plus emergency room copay (waived if admitted to hospital within 3 days of emergency room visit)	In U.S.: \$0 Outside U.S. and Puerto Rico: 20% after \$100 deductible. Limited to \$25,000 per plan year or 60 consecutive days, which ever is greater.	\$0 copay/30% <sup>4,7</sup> coinsurance	\$0 copay / \$150 copay <sup>7</sup> plus 20% In area and out-of-area covered at listed copayment	\$0 copay / \$150 copay <sup>7</sup> plus 20% In area and out-of-area covered at listed copayment	In U.S.: \$0 Outside U.S.: 20% after \$250 deductible

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				Community First, Scott and White	KelseyCare powered by Community Health Choice	
<b>Inpatient hospital</b> (semi-private room and days board, and intensive care unit)	\$0 after the following amounts for each benefit period <sup>5</sup> : \$1,316 deductible for days 1-60 \$329 copay per day (days 61-90) \$658 copay per lifetime reserve day (days 91-150)	\$0	\$0 copay / 30% <sup>4,7</sup> insurance	\$0 <sup>8</sup> If provider doesn't accept Part A, then coverage is \$150 copay/day up to \$750 per admission and \$2,250 per Calendar Year. 20% after copay	\$0 <sup>8</sup> If provider doesn't accept Part A, then coverage is \$150 copay/day up to \$750 per admission and \$2,250 per Calendar Year. 20% after copay	\$0 No limit to the number of days covered by the plan each benefit period <sup>5</sup>
<b>Outpatient surgery</b>	20% Specified copay for outpatient hospital facility charges	\$0	\$0 copay / 30% <sup>4,7</sup> insurance	\$0 copay / \$100 copay <sup>7</sup> plus 20%	\$150 copay <sup>7</sup>	\$0
<b>Skilled nursing facility</b>	Days 1-20: \$0 (3-day hospital stay required) Days 21-100: \$164.50 coinsurance per day Per benefit period <sup>5</sup>	\$0 up to 100 days per benefit period (no 3-day hospital stay is required) You pay 100% after 100 days	No deductible Plan pays 100%	\$0 copay / 20% <sup>7</sup> coinsurance	\$0 copay / 20% <sup>7</sup> coinsurance	Days 1-100: \$0 copayment per day Plan covers up to 100 days each benefit period <sup>5</sup> No prior hospital stay is required
<b>Home health care</b>	\$0	\$0	\$0 copay/30% <sup>4,7</sup> coinsurance for home infusion therapy Plan pays 100% for all other home health care services with a maximum of 100 visits per calendar year	\$0 copay / 20% <sup>7</sup> coinsurance	\$0 copay / 20% <sup>7</sup> coinsurance	\$0
<b>Hospice</b>	5% of the Medicare-approved amount for inpatient respite care \$5 copay for pain management drugs	Same benefits as under Original Medicare	\$0 copay / 30% <sup>4,7</sup> coinsurance	\$0 copay / 20% <sup>7</sup> coinsurance	\$0 copay / 20% <sup>7</sup> coinsurance	Same benefits as under Original Medicare You must receive care from a Medicare-certified hospice
<b>Ambulance</b>	20%	\$0	\$0 copay/30% <sup>4,7</sup> coinsurance Emergency care only. Not applicable to non-emergent transportation services.	\$0 copay / 20% <sup>7</sup> coinsurance	\$0 copay / 20% <sup>7</sup> coinsurance	\$0
<b>Private duty nursing</b>	Does not cover	30% Pays a maximum benefit of \$8,000 per calendar year	30% <sup>4</sup> Unlimited hours Preauthorization is required	\$0 copay / 20% <sup>7</sup> coinsurance	\$0 copay / 20% <sup>7</sup> coinsurance	Does not cover

\*Under the Affordable Care Act, certain preventive health and women's services are paid at 100% (at no cost to the participant) conditioned upon physician billing and diagnosis. In some cases, you may still be responsible for payment on some services. Some age requirements may apply.

<sup>1</sup> One per calendar year.

<sup>2</sup> One per plan year.

<sup>3</sup> No copayment for a pap smear once every 24 months; once every 12 months for those at high risk.

<sup>4</sup> After payment of deductible. HealthSelect note: Medicare and HealthSelect deductibles run concurrently. Participant may be responsible for some charges when the provider does not accept Medicare assignment.

<sup>5</sup> A "benefit period" starts the day you go into the hospital. It ends after 60 days in a row without returning to hospital care. If you go into the hospital after one benefit period has ended, a new benefit period will begin. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you may have.

<sup>6</sup> Copayment amount depends on whether treatment is provided by a PCP or specialist.

<sup>7</sup> Payment amount is dependent upon the coordination of benefits (COB) between your carrier (HealthSelect, Community First, KelseyCare powered by Community Health Choice, Scott & White) and Original Medicare. Sometimes this means your expense is \$0, but charges will vary depending upon COB. Please reference your Summary of Benefits and Coverage for more information.

<sup>8</sup> In the event that the provider/facility does not accept Medicare assignment (so the charges are not covered by Medicare and therefore not subject to COB); you may be responsible for copay(s) and/or a coinsurance. Please see your Summary of Benefits and Coverage for more information.

<sup>9</sup> ERS cannot and does not guarantee the length of time that a specific type of "Value-Added" product shall be offered. Any questions or concerns about these products should be directed to your carrier.










<sup>10</sup> Does not count toward out-of-pocket maximum.

## How much does it cost?

Premiums for ERS Medicare Advantage plans are much lower than what you're paying now to cover a Medicare-eligible dependent. You must continue paying Medicare Part B premiums with all health plans.

## Plan Year 2019 (January 1 – December 31, 2019)

Coverage level	HealthSelect Medicare Advantage Premium	HealthSelect <sup>SM</sup> of Texas Premium	Your savings with HealthSelect Medicare Advantage	KelseyCare Medicare Advantage premium	Your savings with KelseyCare Medicare Advantage
Retiree only	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Retiree & spouse	\$140.92	\$358.00	\$217.08	\$122.38	\$235.62
Retiree & children	\$140.92	\$239.70	\$98.78	\$122.38	\$117.32
Retiree & family	\$281.84	\$597.70	\$315.86	\$244.76	\$352.94
Surviving spouse only	\$281.84	\$716.00	\$434.16	\$244.76	\$471.24
Surviving children only	\$281.84	\$479.40	\$197.56	\$244.76	\$234.64
Surviving spouse & children	\$563.68	\$1,195.40	\$631.72	\$489.52	\$705.88

Plan Name	Plan Administrator	Prescription Drug	Description
<b>HealthSelect MA PPO</b> 	Humana (855) 377-0001	HealthSelect Medicare Rx through UnitedHealthcare 	Humana administers your Medicare; doctors and other providers file one claim with Humana.
<b>HealthSelect<sup>SM</sup> of Texas HealthSelect Secondary</b> 	Blue Cross and Blue Shield of Texas (800) 252 - 8039	HealthSelect Medicare Rx through UnitedHealthcare 	Medicare pays primary and HealthSelect pays secondary.
<b>KelseyCare Advantage MA HMO</b> 	KelseyCare Advantage (Houston area) (877) 853-9075	HealthSelect Medicare Rx through UnitedHealthcare 	KelseyCare Advantage administers your Medicare; doctors and other providers file one claim with KelseyCare Advantage. (available only to members in the Houston area)
<b>Scott &amp; White Health Plan (HMO)</b> 	Scott & White (Central Texas) (800) 321-7947	Argus Health	Medicare pays primary and HMO pays secondary. (available only to members in the Central Texas area)
<b>Community First Health Plans (HMO)</b> 	Community First (San Antonio area) (877) 698-7032	Navitus Health Solutions	Medicare pays primary and HMO pays secondary. (available only to members in the San Antonio area)
<b>KelseyCare powered by Community Health Choice (HMO)</b> 	KelseyCare powered by Community Health Choice (Houston area) (844) 515-4877	Navitus Health Solutions	Medicare pays primary and HMO pays secondary. (available only to members in the Houston area)