ERS®
Employees Retirement System of Texas

HEALTH PLANS COMPARISON CHART
MEDICARE-ELIGIBLE RETIREES
Plan Year 2022 – January 1, 2022 through December 31, 2022

This chart shows your share of costs for commonly used medical, mental health and prescription drug benefits in Original Medicare, the HealthSelect℠ Medicare Advantage Plan, a preferred provider organization (MA PPO), and HealthSelect℠ Secondary. For in-depth information about eligibility, services that are covered and not covered and what you pay, view each plans' Evidence of Coverage or Master Benefit Plan Document on the plan's website. If there is a conflict between the plan documents and this chart, the plan documents will control. View **Medicare.gov** for information about Medicare benefits. Rates and benefits are subject to change.

	Original Medicare	HealthSelect℠ Medicare Advantage Plan In-Network and Out-of-Network	HealthSelect℠ Secondary In-Network and Out-of-Network
Administrator	**Centers for Medicare & Medicaid Services**	**UnitedHealthcare**	**Blue Cross and Blue Shield of Texas (BCBSTX)**
How this plan works	Medicare covers hospital stays (Part A) and certain doctors' services, supplies, preventive services and more (Part B). You can also purchase Part D prescription drug coverage. Providers who accept Medicare submit claims for you. Once you meet your deductible(s), you are responsible for the share of cost listed in this chart.	HealthSelect MA PPO is a Medicare Advantage plan, also known as Medicare Part C. It includes benefits under Medicare Parts A and B plus extra programs. It includes prescription drug coverage through HealthSelect Medicare Rx. You must continue to pay your Part B premiums. This plan has a provider network, but you can see any provider who accepts Medicare and agrees to see you. In-network providers will submit claims for you. There are no deductibles for the medical plan. There is a $50 annual deductible per person for prescription drug coverage. You are responsible for the share of cost listed in this chart.	HealthSelect Secondary pays secondary to Medicare but is not a Medicare Advantage plan. It includes prescription drug coverage through HealthSelect Medicare Rx. You must continue to pay your Part B premiums. The plan has a provider network, but you can see any provider who accepts Medicare. In-network providers will submit claims for you. This plan has higher dependent and tiered premiums and higher out-of-pocket costs than HealthSelect MA PPO. For most Medicare-covered services, your share of costs is usually $0 after you meet your deductibles and after Medicare pays. If Medicare does not cover a service, this plan pays primary. Once you meet your annual deductible(s) you are responsible for the share of cost listed in this chart.
Annual medical deductible	Part A deductible: $1,408 Part B deductible: $198 You must meet your annual deductible before Medicare pays for covered services.	None	Deductible per individual: $200 Deductible per family: $600 You must meet your Medicare AND your HealthSelect Secondary deductibles before the plan pays for covered services. The two deductibles run concurrently.
Out-of-network coverage?	N/A; the benefits below apply to services from any provider who accepts Medicare.	Yes. Out-of-network services are covered at the same benefit levels as long as the provider accepts Medicare and agrees to treat you.	Yes. Most out-of-network services are covered at the same benefit levels as long as the provider accepts Medicare and this plan.
Balance billing? (when an out-of-network provider charges you the difference between their billed charges and amount your plan allows)	No. Balance billing does not apply as long as provider accepts Medicare.	No. Balance billing does not apply as long as provider accepts Medicare.	Yes. Balance billing may apply to certain out-of-network services. When a service is not covered by Medicare or Medicare benefits are exhausted, you could be balance-billed.
Total in-network out-of-pocket maximum	None	$1,000 per person (includes medical services only); resets each calendar year	$6,750 per person or $13,500 per family (includes medical and prescription drug copays, coinsurance and deductibles; excludes non-network and non-covered services); resets each calendar year
Out-of-pocket coinsurance maximum	None	None	$3,000 per person (includes medical coinsurance only); resets each calendar year
Inpatient copay maximum	None	None	None

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.

	Original Medicare	HealthSelect℠ Medicare Advantage Plan In-Network and Out-of-Network	HealthSelect℠ Secondary In-Network and Out-of-Network
Primary care provider (PCP) required?	No	No, but recommended.	No
Referrals required?	No	No	No

Medical Benefits			
	Original Medicare	**HealthSelect℠ Medicare Advantage Plan In-Network and Out-of-Network**	**HealthSelect℠ Secondary In-Network and Out-of-Network**
Allergy treatment	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance
Ambulance services (for emergencies)	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance
Bariatric surgery	Covered for certain conditions related to morbid obesity. Bariatric surgery is covered at the same cost as an inpatient hospital or outpatient hospital visit, depending on where the surgery is performed.	Covered for certain conditions related to morbid obesity. No cost to participant(s) when coverage requirements are met.[1]	Not covered
Chiropractic care	20% coinsurance for Medicare-covered chiropractic services	No cost to participants. Chiropractic services not covered by Medicare are limited to 30 visits per plan year.	$0 copay / 30% coinsurance; maximum of 30 visits per calendar year covered; $75 maximum benefit per visit
Diabetes equipment[1]	20% coinsurance after annual Part B deductible is met; see page 6 for details	No cost to participant(s) for certain brands of equipment; see page 6 for details	$0 copay / 30% coinsurance; see page 6 for details
Diabetes supplies	See page 6 for details		
Diagnostic X-rays and lab tests[3]	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance
Diagnostic mammography	20% coinsurance	No cost to participant(s)	In-network: No cost to participant(s). Out-of-network: Balance billing may apply
Durable medical equipment[1]	20% coinsurance	No cost to participant(s) for Medicare-covered equipment	$0 copay / 30% coinsurance
Eye exam – routine	Not covered	No cost to participant(s) for refraction exam; limited to one exam every 12 months	30% coinsurance; limited to one exam per calendar year
Facility-based providers (radiologists, pathologists and labs, anesthesiologists, emergency room physicians etc.)	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance
Facility emergency care and hospital-affiliated freestanding emergency departments (not freestanding emergency room facilities)	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance
Freestanding emergency room facility (FSER)	Not covered by Medicare	Not covered by Medicare	$0 copay / 30% coinsurance FSERs are not covered by Medicare, so HealthSelect will pay primary.

[1]Preauthorization may be required.

[3]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 Coordination of Benefits (COB), you may be responsible for copay(s) and/or a coinsurance. Please see your Evidence of Coverage or Master Benefit Plan Document for more information.

Medical Benefits			
	Original Medicare	**HealthSelect℠ Medicare Advantage Plan In-Network and Out-of-Network**	**HealthSelect℠ Secondary In-Network and Out-of-Network**
Habilitation and rehabilitation services - outpatient therapy (including physical therapy, occupational therapy and speech therapy)	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance
Hearing aids (for covered participants over age 18)	Not covered	Up to $2,000 allowance for one or both ears every three years	Up to $1,000 allowance per ear for any consecutive 36-month period and $1 per battery. Annual HealthSelect Secondary deductible does not apply.
Hearing test – routine	Not covered	No cost to participant(s); limited to one test per plan year	30% coinsurance
High-tech radiology (CT scan, MRI and nuclear medicine)	20% coinsurance	No cost to participant(s)[1]	$0 copay / 30% coinsurance
Home health care[1]	No cost to participant(s)	No cost to participant(s)	$0 copay / 30% coinsurance for home infusion therapy Plan pays 100% for all other home health care services. Maximum of 100 visits per calendar year when non-network providers are used.
Hospice care[1]	Covered services from Medicare-certified hospice program: • Hospice services and Part A and Part B services related to terminal prognosis • 5% coinsurance for Medicare-approved inpatient respite care • $5 copay for pain management drugs	Services through a Medicare-certified hospice program are covered by Medicare, not HeatlhSelect MA PPO	$0 copay / 30% coinsurance Annual HealthSelect Secondary deductible does not apply.
Hospital - inpatient stay (semi-private room and day's board, and intensive care unit)[1]	$0 after the following amounts for each benefit period[2]: • 1-60 days: $1,408 deductible • 61-90 days: $352 copay per day • 91-150 days: $704 copay per lifetime reserve day	No cost to participant(s)	$0 copay[3] / 30% coinsurance
Medications and injections administered by a provider (see below for outpatient medications and injections)*[1]	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance Preventive vaccines are covered at 100%*
Office surgery and diagnostic procedures	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance

*Under the Affordable Care Act and CMS requirements, 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. Balance-billing may apply for out-of-network providers. Some age requirements may apply.

[1]Preauthorization may be required.

[2]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.

[3]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 Coordination of Benefits (COB), you may be responsible for copay(s) and/or a coinsurance. Please see your Evidence of Coverage or Master Benefit Plan Document for more information.

Medical Benefits			
	Original Medicare	**HealthSelect℠ Medicare Advantage Plan In-Network and Out-of-Network**	**HealthSelect℠ Secondary In-Network and Out-of-Network**
PCP office visit	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance
Preventive Services* (physical, screening mammogram, well woman exam, prostate cancer screening, etc.)	No cost to participant(s) if covered by Medicare*; limited to one screening per type per plan year. Does not cover lab tests.	No cost to participant(s) if covered by Medicare.*	In-network: No cost to participant(s)* Out-of-network: Balance billing may apply
Private duty nursing[1]	Not covered	30% coinsurance The plan covers up to a maximum benefit of $8,000 per calendar year. After that, you are responsible for the full cost of services. Coinsurance does not apply to your annual total out-of-pocket maximum.	30% coinsurance; Unlimited hours
Retail health/ convenience care clinic	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance
Skilled nursing facility (SNF)/ inpatient rehabilitation facility services[1]	Days 1-20: $0 (3-day hospital stay required) Days 21-100: $176 coinsurance per day per benefit period[2]	No cost to participant(s) per 100-day benefit period.[2] Includes unlimited 100-day benefit periods. If services extend beyond 100 days, you are responsible for the full cost of services.	No cost to participant(s) Annual HealthSelect Secondary deductible does not apply
Specialist physician office visit	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance
Surgery (outpatient) other than in physician's office[1]	20% coinsurance; specified copay for outpatient hospital facility charges	No cost to participant(s)	$0 copay / 30% coinsurance
Telemedicine visit	20% coinsurance	No cost to participant(s) for each Medicare-covered telehealth visit	$0 copay / 30% coinsurance
Therapeutic treatments - outpatient	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance
Urgent care clinic	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance
Virtual visits / e-visits (medical)	Not covered	No cost to participant(s) for in-network and out-of-network virtual visit providers	Doctor on Demand or MDLive covered at no cost to participant(s); other providers not covered

*Under the Affordable Care Act and CMS requirements, 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. Balance-billing may apply for out-of-network providers. Some age requirements may apply.

[1]Preauthorization may be required.

[2]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 Medicare inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you may have.

Mental Health/Behavioral Health/Substance Abuse Benefits

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

	Original Medicare	HealthSelect℠ Medicare Advantage Plan In-Network and Out-of-Network	HealthSelect℠ Secondary In-Network and Out-of-Network
Administrator and network	N/A	Optum Behavioral Health Network	Blue Cross and Blue Shield of Texas
Inpatient hospital mental health stay[1]	$0 after the following amounts for each benefit period[2]: • Days 1-60: $1,408 deductible • Days 61-90: $352 copay per day • Days 91-150: $704 copy per lifetime reserve day	No cost to participant(s). Limited to 190 days in a psychiatric hospital over lifetime	$0 copay[3] / 30% coinsurance
Mental health telemedicine	20% coinsurance	No cost to participant(s) for each Medicare-covered telehealth visit	$0 copay / 30% coinsurance
Outpatient facility care (partial hospitalization/ day treatment and extensive outpatient treatment)[1]	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance
Outpatient physician or mental health provider office visit	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance
Virtual visits / e-visits (mental health)	Not covered	No cost to participant(s) for in-network and out-of-network virtual visit providers.	Doctor on Demand or MDLive covered at no cost to participant(s); other providers not covered.

[1]Preauthorization may be required.

[2]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.

[3]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 Coordination of Benefits (COB)), you may be responsible for copay(s) and/or a coinsurance. Please see your Evidence of Coverage or Master Benefit Plan Document for more information.

Prescription Drug Benefits

HealthSelect MA PPO and HealthSelect Secondary include comprehensive prescription drug coverage through HealthSelect℠ Medicare Rx, administered by UnitedHealthcare.

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, Extended Days Supply Pharmacy (EDS) or mail service pharmacy. You will pay less for your drugs when you fill your prescription at a network pharmacy.

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.

	Original Medicare	HealthSelect℠ Medicare Advantage Plan In-Network and Out-of-Network	HealthSelect℠ Secondary In-Network and Out-of-Network
Pharmacy benefits manager (PBM)	You must be enrolled in an eligible Medicare Part D plan. If you are not enrolled in a Part D plan, you do not have coverage for prescription drugs.	UnitedHealthcare	UnitedHealthcare
Out-of-network benefits?[4]	Depends on Medicare Part D prescription drug plan and benefits	Yes	Yes
Prescription Drug Plan (PDP) deductible (per participant, per plan year)	Depends on Part D plan	$50	$50
Tier 1 (mostly generic drugs)	Depends on Part D plan	• Nonmaintenance and maintenance: $10 copay • 90 days' supply mail order or extended day supply: $30 copay	• Nonmaintenance and maintenance: $10 copay • 90 days' supply mail or extended day supply: $30 copay

[4] Out-of-network prescriptions and diabetic supplies may be covered in certain situations, depending on Medicare requirements and your specific circumstance. Your prescription may be covered in certain situations. Your cost may be greater if you use an out-of-network pharmacy to fill your prescription, and you must submit a paper claim in order to be reimbursed.

Prescription Drug Benefits			
	Original Medicare	**HealthSelect℠ Medicare Advantage Plan In-Network and Out-of-Network**	**HealthSelect℠ Secondary In-Network and Out-of-Network**
Tier 2 (mostly preferred brand name drugs)[1]	Depends on Part D plan	• Nonmaintenance: $35 copay • Maintenance: $45 copay • Mail order or extended day supply: $105 copay	• Nonmaintenance: $35 copay • Maintenance: $45 copay • Mail order or extended day supply: $105 copay
Tier 3 (mostly non-preferred brand name drugs)[1]	Depends on Part D plan	• Nonmaintenance: $60 copay • Maintenance: $75 copay • Mail order or extended day supply: $180 copay	• Nonmaintenance: $60 copay • Maintenance: $75 copay • Mail order or extended day supply: $180 copay
Specialty drugs[1]	Depends on Part D plan	Specialty drugs purchased through a pharmacy are covered as either Tier 2 or Tier 3 drugs. Otherwise they are covered as a medical benefit.	Specialty drugs purchased through a pharmacy are covered as either Tier 2 or Tier 3 drugs. Otherwise they are covered as a medical benefit.

[1]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 medical and prescription drug plan benefits, refer to the contact information on page 16 of your Fall Enrollment guide or on the back of your ID card for your medical or prescription drug plan.

Supply	Original Medicare	HealthSelect MA PPO (HealthSelect℠ Medicare Rx) In-Network and Out-of-Network		HealthSelect℠ Secondary (HealthSelect℠ Medicare Rx) In-Network and Out-of-Network	
	Medical and prescription drug benefits	**Prescription Drug Plan (PDP) benefits (UnitedHealthcare)**	**Medical plan benefits (UnitedHealthcare)**	**Prescription Drug Plan (PDP) benefits (UnitedHealthcare)**	**Medical plan benefits (BCBSTX)**
Diabetes Glucometers	Covered under Medicare Part B; 20% coinsurance	Not covered under PDP benefits	No cost to participant(s) for certain brands of glucometers. Covered glucometers include: OneTouch Verio Flex®, OneTouch Verio Reflect®, OneTouch® Ultra 2, Accu-Chek® Guide Me and AccuChek® Guide. Other brands may not be covered.	Not covered under PDP benefits	$0 copay / 30% coinsurance
Diabetes glucometer test strips	Covered under Medicare Part B; 20% coinsurance	Not covered under PDP benefits	No cost to participant(s) for certain brands of test strips. Covered test strips include: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus and AccuChek® SmartView. Other brands may not be covered.	Not covered under PDP benefits	$0 copay / 30% coinsurance
Other diabetes supplies[1,4]	Covered under Medicare Part D; deductible, coinsurance and/or copay may apply, depending on Part D plan benefits.	In-network pharmacy: Insulin syringes and pen needles are covered at no cost to participants. Some supplies may be covered under medical plan benefits.	No cost to participant(s) for preferred covered diabetes montioring supplies, including lancets and lancing devices. Certain brands of diabetes supplies may not be covered. For more information, contact HealthSelect MA PPO.	In-network pharmacy: Insulin syringes and pen needles are covered at no cost to participants. Some supplies may be covered under medical plan benefits.	$0 copay / 30% coinsurance Some supplies may be covered under PDP benefits. For more information, contact HealthSelect Secondary.
Prescription insulin[1,4]	Covered under Medicare Part D; deductible, coinsurance and/or copay may apply, depending on Part D plan benefits.	In-network pharmacy: Insulin products on the PDP drug list (formulary) are covered at a Tier 2 or Tier 3 copay. The annual PDP deductible does not apply to formulary insulin beginning 1/1/22.	Not covered under medical plan benefits	In-network pharmacy: Insulin products on the PDP drug list (formulary) are covered at a Tier 2 or Tier 3 copay. The annual PDP deductible does not apply to formulary insulin beginning 1/1/22.	Not covered under medical plan benefits

[1]Preauthorization may be required.

[4] Out-of-network prescriptions and diabetic supplies may be covered in certain situations, depending on Medicare requirements and your specific circumstance. Your prescription may be covered in certain situations. Your cost may be greater if you use an out-of-network pharmacy to fill your prescription, and you must submit a paper claim in order to be reimbursed.