ERS®
EMPLOYEES RETIREMENT SYSTEM OF TEXAS

HEALTH PLANS COMPARISON CHART
MEDICARE-ELIGIBLE RETIREES
PLAN YEAR 2025 – JAN. 1 THROUGH DEC. 31, 2025

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 preferred provider organization (MA PPO), and HealthSelect℠ Secondary. For in-depth information about eligibility, services that are covered, 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 Original 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. **Note:** Medicare will not reimburse claims for services rendered by providers who do not participate in Medicare. 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 additional benefits and 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 participates in Medicare. 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. This 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	Not available at time of printing. 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?	The benefits below apply to services from any provider who participates in Medicare.	Yes. Out-of-network services are covered at the same benefit levels as long as the provider participates in Medicare and agrees to treat you.	Yes. Most out-of-network services are covered at the same benefit levels as long as the provider participates in 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 the provider participates in Medicare.	No. Balance billing does not apply as long as the provider participates in 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 (for medical services only) resets each calendar year. Pharmacy and additional benefits such as private duty nursing do not apply.	$8,050 per person or $16,100 per family (includes medical and prescription drug copays, coinsurance and deductibles; excludes out-of-network and non-covered services); resets each calendar year
Out-of-pocket coinsurance maximum	None	None. There is a 30% coinsurance for private duty nursing, which does not apply to the maximum out-of-pocket.	$3,000 per person (includes medical coinsurance only); resets each calendar year
Inpatient copay maximum	None	N/A	N/A
Primary care provider (PCP) required?	No	No, but recommended.	No
Referrals required?	No	No	No

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.

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[2]
Ambulance transportation (for emergencies)	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance[2]
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 participant(s). Chiropractic services not covered by Medicare are limited to 30 visits per plan year.	$0 copay / 30% coinsurance[2]; maximum of 30 visits per calendar year covered; $75 maximum benefit per visit
Diabetes equipment	20% coinsurance after annual Part B deductible is met; see page 6 for details	No cost to participant(s) for certain brands of equipment[1]; see page 6 for details	$0 copay / 30% coinsurance[2]; see page 6 for details
Diabetes supplies	See page 6 for details		
Diagnostic X-rays and lab tests	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance[2]
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	20% coinsurance	No cost to participant(s) for Medicare-covered durable medical equipment.[1]	$0 copay / 30% coinsurance[2]
Eye exam – routine	Not covered	No cost to participant(s) for refraction exam; limited to one exam every 12 months	$0 copay / 30% coinsurance[2]; 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[2]
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[2]
Freestanding emergency room facility (FSER)	Not covered by Medicare	Not covered by Medicare	$0 copay / 30% coinsurance[2] FSERs are not covered by Medicare, so HealthSelect will pay primary.
Habilitation and rehabilitation services – outpatient (including physical, occupational and speech therapy**)**	20% coinsurance	No cost to participant(s)[1]	$0 copay / 30% coinsurance[2]
Hearing aids requiring a prescription (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. A valid prescription for the hearing aid(s) must be submitted with your claim.

[1] Preauthorization may be required.

[2] In the event that the provider/facility opts out of Medicare (so the charges are not covered by Medicare and therefore not subject to Coordination of Benefits (COB)), you may be responsible for your deductible and/or coinsurance. Please see your Master Benefit Plan Document for more information.

Medical Benefits			
	Original Medicare	**HealthSelectSM Medicare Advantage Plan In-Network and Out-of-Network**	**HealthSelectSM Secondary In-Network and Out-of-Network**
Hearing test – routine	Not covered	No cost to participant(s); limited to one test per plan year	30% coinsurance[3]
High-tech radiology (CT scan, MRI and nuclear medicine)	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance[3]
Home health care	No cost to participant(s)	No cost to participant(s)[1]	$0 copay / 30% coinsurance for home infusion therapy[3] Plan pays 100% for all other home health care services. Maximum of 100 visits per calendar year when out-of-network providers are used.
Hospice care	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 HealthSelect MA PPO	$0 copay / 30% coinsurance[3] Annual HealthSelect Secondary deductible does not apply.
Hospital - inpatient stay (semi-private room and day's board, and intensive care unit)	$0 after the following amounts for each benefit period[2]: • 1-60 days: $1,600 deductible (through Dec. 31, 2023) • 61-90 days: $400 copay per day (through Dec. 31, 2023) • 91-150 days: $800 copay (through Dec. 31, 2023) per lifetime reserve day	No cost to participant(s)	$0 copay / 30% coinsurance[3]
Medications and injections administered by a provider (see below for outpatient medications and injections)*	20% coinsurance for Medicare Part B covered prescription drugs under certain conditions	No cost to participant(s) for Medicare Part B covered prescription drugs under certain conditions	$0 copay / 30% coinsurance[3] Preventive vaccines are covered at 100%*
Office surgery and diagnostic procedures	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance[3]
PCP office visit	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance[3]
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	Not covered	30% coinsurance[1] 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[3]

* 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 opts out of Medicare (so the charges are not covered by Medicare and therefore not subject to Coordination of Benefits (COB)), you may be responsible for your deductible and/or coinsurance. Please see your 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
Retail health/ convenience care clinic	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance[3]
Skilled nursing facility (SNF)/inpatient rehabilitation facility services	Days 1-20: $0 (3-day hospital stay required Days 21-100: up to $200 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.[1]	No cost to participant(s)[3] Annual HealthSelect Secondary deductible does not apply.
Specialist physician office visit	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance[3]
Surgery (outpatient) **other than in physician's office**	20% coinsurance; specified copay for outpatient hospital facility charges	No cost to participant(s)[1]	$0 copay / 30% coinsurance[3]
Telemedicine visit	20% coinsurance	No cost to participant(s) for each Medicare-covered telehealth visit	$0 copay / 30% coinsurance[3]
Therapeutic treatments - outpatient	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance[3]
Urgent care clinic	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance[3]
Virtual Visits / e-visits (medical)	20% coinsurance	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 virtual 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.

[3] In the event that the provider/facility opts out of Medicare (so the charges are not covered by Medicare and therefore not subject to Coordination of Benefits (COB)), you may be responsible for your deductible and/or coinsurance. Please see your Master Benefit Plan Document for more information

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	Medicare Part A covers mental health services you get when you are admitted as a hospital patient. For each benefit period[2], you will pay: • Days 1–60: $0 coinsurance per day, after $1,600 deductible (through Dec. 31, 2023) • Days 61–90: $400 coinsurance per day (through Dec. 31, 2023) • Days 91 and beyond: $800 coinsurance (through Dec 31, 2023) per each "lifetime reserve day" after day 90 for each benefit period (up to a maximum of 60 reserve days over your lifetime) • If services extend beyond the lifetime reserve days, you are responsible for the full cost of services • 20% of the Medicare-approved amount for mental health services you get from doctors and other providers while you are a hospital inpatient	No cost to participant(s)[1] Limited to 190 days in a psychiatric hospital over lifetime	$0 copay / 30% coinsurance[3]
Mental health telemedicine	20% coinsurance	No cost to participant(s) for each Medicare-covered telehealth visit	$0 copay / 30% coinsurance[3]

[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 opts out of Medicare (so the charges are not covered by Medicare and therefore not subject to Coordination of Benefits (COB)), you may be responsible for your deductible and/or coinsurance. Please see your Master Benefit Plan Document for more information

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
Outpatient facility care (partial hospitalization/day treatment and extensive outpatient treatment)[1]	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance[3]
Outpatient physician or mental health provider office visit	20% coinsurance	No cost to participant(s)	$0 copay / 30% coinsurance[3]
Virtual Visits / e-visits (mental health)	20% coinsurance when it meets Medicare criteria	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 virtual 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 opts out of Medicare (so the charges are not covered by Medicare and therefore not subject to Coordination of Benefits (COB)), you may be responsible for your deductible and/or coinsurance. Please see your 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 Express Scripts Medicare®.

The cost share you pay for your medication depends on its drug tier, the quantity you purchase (30-, 60- or 90-day supply) and whether the prescription is filled at a retail pharmacy, Extended Days Supply Pharmacy (EDS) or mail order pharmacy. Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. Please see the Evidence of Coverage for more information on coverage when using an out-of- 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.	Express Scripts Medicare PDP	Express Scripts Medicare PDP
Out-of-network benefits?[1]	Depends on Medicare Part D prescription drug plan and benefits	Limited[1]	Limited[1]
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	Non-maintenance and maintenance: $10 copay 90 days' supply mail order or EDS: $30 copay	Non-maintenance and maintenance: $10 copay 90 days' supply mail order or EDS: $30 copay
Tier 2 (mostly preferred brand name drugs)	Depends on Part D plan	• Non-maintenance: $35 copay • Maintenance: $45 copay 90 days' supply mail order or EDS: $105 copay	• Non-maintenance: $35 copay • Maintenance: $45 copay 90 days' supply mail order or EDS: $105 copay
Tier 3 (mostly non-preferred brand name drugs)[1]	Depends on Part D plan	• Non-maintenance: $60 copay • Maintenance: $75 copay 90 days' supply mail order or EDS: $180 copay	• Non-maintenance: $60 copay • Maintenance: $75 copay 90 days' supply mail order or EDS: $180 copay
Specialty drugs	Depends on Part D plan	Specialty drugs purchased through a pharmacy are covered as either Tier 2 or Tier 3 drugs. Some Specialty drugs are covered as a medical benefit.[2]	Specialty drugs purchased through a pharmacy are covered as either Tier 2 or Tier 3 drugs. Some Specialty drugs are covered as a medical benefit.[2]

[1] Out-of-network prescriptions and diabetic supplies may be covered in certain situations, depending on Medicare requirements and your specific circumstance. 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.

[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 medical and prescription drug program 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 Program (PDP) benefits (Express Scripts Medicare®)	Medical plan benefits (UnitedHealthcare®)	Prescription Drug Program (PDP) benefits (Express Scripts Medicare®)	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®Ultra 2, AccuChek® Guide Me and Accu-Chek® Guide. Other brands may not be covered.	Not covered under PDP benefits	$0 copay / 30% coinsurance[3]
Continuous glucose monitors / insulin pumps	Certain brands of continuous glucose monitors and related supplies may be covered.	Not covered under PDP benefits	Certain brands of continuous glucose monitors and related supplie. Your provider may need to obtain prior authorization.	Not covered under PDP benefits	$0 copay / 30% coinsurance[3]
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 Accu-Chek® SmartView. Other brands may not be covered.	Not covered under PDP benefits	$0 copay / 30% coinsurance[3]
Diabetes supplies[1,2]	Covered under Medicare Part D; deductible, coinsurance and/or copay may apply, depending on Part D plan benefits. There are some diabetic supplies available under Medicare Part B with a 20% coinsurance.	Insulin syringes and pen needles are covered at no cost to participants. Some supplies, such as lancets and test strips, are covered under medical Medicare Part B.	No cost to participant(s) for preferred covered diabetes monitoring supplies, including lancets and lancing devices. Certain brands of diabetes supplies may not be covered. For more information, contact HealthSelect MA PPO.	Insulin syringes and pen needles are covered at no cost to participants. Some supplies, such as lancets and test strips, are covered under medical plan benefits.	$0 copay / 30% coinsurance[3] For more information, contact BCBSTX.
Prescription insulin[1,2]	Covered under Medicare Part D; Insulin products on the plan's formulary are covered at no more than $35 per 30-day supply.	Insulin products on the PDP drug list (formulary) are covered at no more than $25 per 30-day supply, regardless of tier. The annual PDP deductible does not apply to formulary insulin.	Not covered under medical plan benefits	Insulin products on the PDP drug list (formulary) are covered at no more than $25 per 30-day supply, regardless of tier. The annual PDP deductible does not apply to formulary insulin.	Not covered under medical plan benefits

[1] Preauthorization may be required.

[2] 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.

[3] In the event that the provider/facility opts out of Medicare (so the charges are not covered by Medicare and therefore not subject to Coordination of Benefits (COB)), you may be responsible for your deductible and/or coinsurance. Please see your Master Benefit Plan Document for more information