ERS®
Employees Retirement System of Texas

EMPLOYEE AND NON-MEDICARE-ELIGIBLE RETIREE HEALTH PLANS COMPARISON CHART

EFFECTIVE SEPTEMBER 1, 2020

	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 Plan In Network	Consumer Directed HealthSelect High-deductible Plan Out of Network	Community First Health Plans HMO In Network	Scott and White Health Plan HMO In Network
Annual deductible	None	$500 per individual, $1,500 per family	$2,100 per individual, $4,200 per family Note: To help cover part of the deductible, the State contibutes to an eligible member's health savings account: $540/year for an individual, $1,080/ year for a family.	$4,200 per individual, $8,400 per family Note: To help cover part of the deductible, the State contibutes to an eligible member's health savings account: $540/year for an individual, $1,080/ year for a family.	None	None
Out-of-network benefits?		Yes. See below for benefit details for out-of-network services.		Yes. See below for benefit details for out-of-network services.	No, except for emergency and urgent care services, services provided by out-of-network facility-based providers in a network facility, and out-of-network services that are authorized in advance by the plan.	No, except for emergency and urgent care services, services provided by out-of-network facility-based providers in a network facility, and out-of-network services that are authorized in advance by the plan.
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.	No. Out-of-network benefits are not covered unless authorized in advance or an emergency, so balance billing does not apply.	No. Out-of-network benefits are not covered unless authorized in advance or an emergency, so typically balance billing should not apply.
Total in-network out-of-pocket maximum (including deductibles, coinsurance and copays)[1]	$6,750 per person, $13,500 per family These reset on January 1.		$6,750 per person, $13,500 per family These reset on January 1.		$6,750 per person, $13,500 per family These reset on September 1.	$6,750 per person, $13,500 per family These reset on September 1.
Out-of-pocket coinsurance maximum	$2,000 per person	$7,000 per person	None	None	$2,000 per person	$2,000 per person
Inpatient copay maximum	$750 copay max, up to five days per hospital stay $2,250 copay max per calendar year per person	$750 copay max, up to five days per hospital stay $2,250 copay max per calendar year per person	None	None	$750 copay max, up to five days per hospital stay $2,250 copay max per plan year per person	$750 copay max, up to five days per hospital stay $2,250 copay max per plan year per person
Primary care provider (PCP) required?	Yes for participants who live and work in Texas; No for out-of-state participants	No	No	No	Yes	No
Referrals required?	Yes for participants who live and work in Texas; No for out-of-state participants as well	No	No	No	No	No

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

Medical Benefits - Member's Share of the Cost

	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 Plan In Network	Consumer Directed HealthSelect High-deductible Plan Out of Network	Community First Health Plans HMO In Network	Scott and White Health Plan HMO In Network
Allergy treatment	No cost to participant(s) if administered in a physician's office, 20% in any other outpatient location	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	20%	20%
Ambulance services (for emergencies)	20%	20%, annual deductible does not apply	20% coinsurance after the annual deductible is met	20% coinsurance after the annual in-network deductible is met	20%	20%
Bariatric surgery[2]	Deductible: $5,000 Coinsurance: 20% Lifetime max: $13,000	Not covered	Not covered	Not covered	Not covered	Not covered
Chiropractic care	20% if billed without an office visit; $40 copay plus 20% with office visit; $75 maximum benefit per visit; 30 visits max per participant per calendar year	40% coinsurance after the annual deductible is met $75 maximum benefit per visit; 30 visits max per participant per calendar year	20% coinsurance after the annual deductible is met $75 maximum benefit per visit; 30 visits max per participant per calendar year	40% coinsurance after the annual deductible is met $75 maximum benefit per visit; 30 visits max per participant per calendar year	$40 copay plus 20%; $75 maximum benefit per visit; 30 visits max per participant per calendar year	$40 copay plus 20% with office visit; No per-visit limit on maximum; 35 visits max per participant per calendar year
Diabetes equipment[2]	20%	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	20%	20%
Diabetes supplies	20%. Covered under the medical and pharmacy plan*	20%, annual deductible does not apply	20% coinsurance after the annual deductible is met. Covered under the medical and pharmacy plan*	20% coinsurance after the annual in-network deductible is met	20% for in-network supplies only, no out-of-network coverage. Covered under the pharmacy plan	20% for in-network supplies only, no out-of-network coverage. Covered under the pharmacy plan
Diagnostic X-rays and lab tests	20%	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	20%	20%
Diagnostic mammography	No cost to participant(s)	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	No cost to participant(s)	No cost to participant(s)
Durable medical equipment[2]	20%	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	20%	20%
Facility-based providers (radiologists, pathologists and labs, anesthesiologists, emergency room physicians etc.)	20%	For emergencies, 20% coinsurance and annual deductible does not apply. For non-emergencies, 40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	For emergencies, 20% coinsurance after the annual in-network deductible is met. For non-emergencies, 40% coinsurance after the annual out-of-network deductible is met.	20%	20%
Facility emergency care and hospital-affiliated freestanding emergency departments (Does not apply to freestanding emergency rooms not affiliated with a hospital.)	$150 copay plus 20% (If admitted, copay will apply to hospital copay.)	$150 copay plus 20% (If admitted, copay will apply to hospital copay.) Annual deductible does not apply. For non-emergencies, $150 copay plus 40% coinsurance after the annual out-of-network deductible is met	20% coinsurance after the annual deductible is met	For emergencies, 20% coinsurance after the annual in-network deductible is met. For non-emergencies, 40% coinsurance after the annual out-of-network deductible is met	$150 plus 20% (If admitted, copay will apply to hospital copay.)	$150 plus 20% (If admitted, copay will apply to hospital copay.)

*Some diabetic supplies are covered at no cost to participant(s) under the pharmacy plan. (Consumer Directed HealthSelect participants must meet their annual deductible first.) For more information, see your pharmacy plan's Master Benefit Plan Document.

[2]Preauthorization may be required.

	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 Plan In Network	Consumer Directed HealthSelect High-deductible Plan Out of Network	Community First Health Plans HMO In Network	Scott and White Health Plan HMO In Network
Freestanding emergency room facility	$150 copay plus 20%	$300 copay plus 20%. Annual deductible does not apply. For non-emergencies, $300 copay plus 40% coinsurance after the annual out-of-network deductible is met	20% coinsurance after the annual deductible is met	For emergencies, 20% coinsurance after the annual in-network deductible is met. For non-emergencies, 40% coinsurance after the annual out-of-network deductible is met	$150 copay plus 20% for in-network and out-of-network	$150 copay plus 20% for in-network and out-of-network
Habilitation and rehabilitation services - outpatient therapy (including physical therapy, occupational therapy and speech therapy)	20%	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	20% coinsurance without office visit, $40 plus 20% coinsurance with office visit	20% coinsurance without office visit, $40 plus 20% coinsurance with office visit
Hearing aids (for covered participants over age 18)	HealthSelect of Texas and HealthSelect Out-of-State pay up to $1,000 per ear every three years and cover in-network and out-of-network hearing aids at the same benefit level.		Consumer Directed HealthSelect pays up to $1,000 per ear every three years (after deductible is met) and covers in-network and out-of-network hearing aids at the same benefit level.		Plan pays up to $1,000 per ear every three years. No out-of-network benefits available	Plan pays up to $1,000 per ear every three years. No out-of-network benefits available
Hearing aids (for participants age 18 and under)	HealthSelect of Texas and HealthSelect Out-of-State pay 100%, limit of one per ear every three years, and cover in-network and out-of-network hearing aids at the same benefit level.		Consumer Directed HealthSelect pays 80% after the annual in-network deductible is met and covers in-network and out-of-network hearing aids at the same benefit level.		20%, limit of one per ear every 3 years	20%, limit of one per ear every 3 years
High-tech radiology (CT scan, MRI and nuclear medicine)[2]	$100 copay plus 20%	$100 copay plus 40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	$100 copay plus 20%	$100 copay plus 20%
Home health care[2]	20%	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	20%	20%
Hospice care[2]	20%	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	20%	20%
Inpatient hospital facility (semi-private room and day's board, and intensive care unit)[2]	$150/day copay plus 20% ($750 copay max, up to five days per hospital stay. $2,250 copay max per calendar year per person)	$150/day copay plus 40% after the annual deductible is met. ($750 copay max, up to five days per hospital stay. $2,250 copay max per calendar year per person)	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	$150/day copay plus 20% ($750 copay max, up to five days per hospital stay. $2,250 copay max per plan year per person)	$150/day copay plus 20% ($750 copay max, up to five days per hospital stay. $2,250 copay max per plan year per person)
Maternity care doctor charges only; inpatient hospital copays will apply	$25 or $40 for first prenatal visit. No charge for routine post natal appointments	40% coinsurance after the annual deductible is met	No charge for routine prenatal appointments. 20% coinsurance for first postnatal visit after the annual deductible is met	40% coinsurance after the annual deductible is met	No charge for routine prenatal appointments. $25 or $40 for first postnatal visit	No charge for routine prenatal appointments. $25 or $40 for first postnatal visit
Medications and injections administered by a provider (see below for outpatient medications and injections)[2]	No cost to participant(s) after you pay the copay if administered in a physician's office*, 20% in any other outpatient location. *No cost to participant(s) if no office visit charge is assessed. Preventive vaccines covered at 100%	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met. Preventive vaccines covered at 100%	40% coinsurance after the annual deductible is met	Covered at benefits throughout chart dependent on where they are administered. Preventive vaccines covered at 100%	Covered at benefits throughout chart dependent on where they are administered. Preventive vaccines covered at 100%

[2]Preauthorization may be required.

	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 Plan In Network	Consumer Directed HealthSelect High-deductible Plan Out of Network	Community First Health Plans HMO In Network	Scott and White Health Plan HMO In Network
Office surgery and diagnostic procedures	20%	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	20%	20%
PCP office visit	$25 copay	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	$25 copay	$25 copay
Private-duty nursing[2]	20%	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	20%	20%
Retail health/ convenience care clinic	$25 copay	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	Not covered	$25 copay
Routine eye exam, one per year per participant	$40 copay	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	$40 copay	$40 copay
Routine preventive care	No cost to participant(s)	40% coinsurance after the annual deductible is met	No cost to participant(s)	40% coinsurance after the annual deductible is met	No cost to participant(s)	No cost to participant(s)
Skilled nursing facility/inpatient rehabilitation facility services[2]	20%	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	20%	20%
Specialist physician office visit	$40 copay	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	$40 copay	$40 copay
Surgery (outpatient) other than in physician's office[2]	$100 copay plus 20%	$100 copay plus 40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	$100 copay plus 20%	$100 copay plus 20%
Telemedicine visit	Coverage is based on place of treatment billed ($25/$40 copay if physician's office visit, 20% for any other outpatient telemedicine).	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	Coverage is based on place of treatment billed ($25 copay if physician's office visit, 20% for any other outpatient telemedicine).	Coverage is based on place of treatment billed ($25 copay if physician's office visit, 20% for any other outpatient telemedicine).
Therapeutic treatments - outpatient	20%	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	20%	20%
Urgent care clinic	$50 copay plus 20%	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	$50 copay plus 20%	$50 copay plus 20%
Virtual visits/ e-visits (medical)	No cost to participant(s) if Doctor on Demand or MDLive is used	Not covered	20% coinsurance after the annual deductible is met	Not covered	No virtual visit or e-visit benefits offered	Virtual Visits/E-visits with a Scott and White Health Plan provider covered at 100% through online portal or app

[2]Preauthorization may be required.

Mental Health/Behavioral Health/Substance Abuse Benefits – Member's Share of Cost

	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 Plan In Network	Consumer Directed HealthSelect High-deductible Plan Out of Network	Community First Health Plans HMO In Network	Scott and White Health Plan HMO In Network
Mental health administrator and network	BCBSTX effective September 1, 2020	BCBSTX effective September 1, 2020	BCBSTX effective September 1, 2020	BCBSTX effective September 1, 2020	CFHP	SWHP
Inpatient hospital mental health stay[2]	$150/day copay plus 20% ($750 copay max, up to five days per hospital stay. $2,250 copay max per calendar year per person)	$150/day copay plus 40% after the annual deductible is met. ($750 copay max, up to five days per hospital stay. $2,250 copay max per calendar year per person)	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	$150/day copay plus 20% ($750 copay max, up to five days per hospital stay. $2,250 copay max per plan year per person)	$150/day copay plus 20% ($750 copay max, up to five days per hospital stay. $2,250 copay max per plan year per person)
Mental health telemedicine	Coverage is based on place of treatment billed ($25 copay if mental health office visit, 20% for any other outpatient telemedicine)	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	Coverage is based on place of treatment billed.	Coverage is based on place of treatment billed ($25 copay if mental health office visit, 20% for any other outpatient telemedicine)
Outpatient facility care (partial hospitalization/ day treatment and extensive outpatient treatment)[2]	20%	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	20%	20%
Outpatient physician or mental health provider office visit	$25 copay	40% coinsurance after the annual deductible is met	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	$25 copay	$25 copay
Virtual visits / e-visits (mental health)	$25 copay for mental health virtual visits provided by Doctor on Demand or MDLive	Not covered	20% coinsurance after the annual deductible is met	Not covered	Not covered	Not covered

[2]Preauthorization may be required.
Benefits listed in cells above apply to all covered mental health/behavioral health/substance abuse services (including serious mental illness treatment, substance abuse treatment, autism spectrum disorder services etc.).

Prescription Drug Benefits and Coverage – Member's Share of Cost

NOTE: PBMs have different formularies and covered drugs, based on the determinations of their own pharmacy and therapeutics committees and individual formulary strategies. Drugs covered under the HealthSelect plan may not be the same drugs covered under CFHP or SWHP.

Pharmacy benefits manager (PBM)	OptumRx (UnitedHealthcare)	OptumRx (UnitedHealthcare)	OptumRx (UnitedHealthcare)	OptumRx (UnitedHealthcare)	Navitus	SWHP
Out-of-network benefits?		Yes		Yes	No	No
Deductible	$50 prescription drug deductible per participant per calendar year applies before the plan pays for any prescription drugs	$50 prescription drug deductible per participant per calendar year applies before the plan pays for any prescription drugs	$2,100 per individual, $4,200 per family. Medical and prescription drug expenses apply to the deductible.	$4,200 per individual, $8,400 per family. Medical and prescription drug expenses apply to the deductible.	$50 deductible per participant per plan year applies before the plan pays for any prescription drugs	$50 deductible per participant per plan year applies before the plan pays for any prescription drugs
Tier 1 (mostly generic drugs)	$10 copayment (nonmaintenance), $10 copayment (maintenance); $30 copayment (90-day supply mail order or extended day supply pharmacy)	$10 copayment plus 40% coinsurance (non-maintenance) $10 copayment plus 40% coinsurance (maintenance); $30 copayment plus 40% coinsurance (mail order or extended day supply)	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	$10 copayment (non-maintenance), $10 copayment (maintenance), $30 copayment (90-day supply mail order or extended day supply)	$10 copayment (non-maintenance), $10 copayment (maintenance), $30 copayment (90-day supply mail order or extended day supply)
Tier 2 (mostly preferred brand-name drugs)[2,3]	$35 copayment (nonmaintenance), $45 copayment (maintenance); $105 copayment (mail order or extended day supply	$35 copayment plus 40% coinsurance (non-maintenance) $45 copayment plus 40% coinsurance (maintenance); $105 copayment plus 40% coinsurance (mail order or extended day supply)	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	$35 copayment (nonmaintenance), $45 copayment (maintenance); $105 copayment (mail order or extended day supply	$35 copayment (nonmaintenance), $45 copayment (maintenance); $105 copayment (mail order or extended day supply
Tier 3 (mostly non-preferred brand-name drugs)[2,3]	$60 copayment (non-maintenance), $75 copayment (maintenance); $180 copayment (mail order or extended day supply)	$60 copayment plus 40% coinsurance (non-maintenance) $75 copayment plus 40% coinsurance (maintenance); $180 copayment plus 40% coinsurance (mail order or extended day supply)	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	$60 copayment (non-maintenance), $75 copayment (maintenance); $180 copayment (mail order or extended day supply)	$60 copayment (non-maintenance), $75 copayment (maintenance); $180 copayment (mail order or extended day supply)
Specialty drugs[2,3]	If purchased through a pharmacy, specialty drugs are covered as preferred brand drugs or nonpreferred brand drugs as listed above. Otherwise, covered as a medical benefit.	If purchased through a pharmacy, specialty drugs are covered as preferred brand drugs or nonpreferred brand drugs as listed above. Otherwise, covered as a medical benefit.	20% coinsurance after the annual deductible is met	40% coinsurance after the annual deductible is met	If purchased through a pharmacy, specialty drugs are covered as preferred brand drugs or nonpreferred brand drugs as listed above. Otherwise, covered as a medical benefit.	If purchased through a pharmacy, specialty drugs are covered as preferred brand drugs or nonpreferred brand drugs as listed above. Otherwise, covered as a medical benefit.
Syringes for insulin administration	$0 copay	$0 copay	$0 copay	$0 copay	$35 copay for 30 days' supply, $105 copay for 90-day supply	$35 copay for 30 days' supply, $105 copay for 90-day supply

[2]Preauthorization may be required.

[3]Tier 2 and Tier 3 : If a generic is available and you choose to buy the brand-name medication, you will pay the generic copay plus the cost difference between the brand-name and the generic medication.