

HEALTHSELECTSM SECONDARY

How does it work?

This plan coordinates your medical plan benefits with Medicare. If you have questions about who pays first or how this plan processes benefits when you have Medicare, contact a Blue Cross and Blue Shield of Texas (BCBSTX) Personal Health Assistant toll-free at **(800) 252-8039 (TTY: 711)**.

If you need details about your Medicare benefits, call Medicare toll-free at **(800) 633-4227** or visit **Medicare.gov**.

Who is eligible?

You are eligible if you are:

- a retiree who is Medicare eligible.
- a Medicare-eligible return-to-work retiree who chooses retiree benefits.
- a Medicare-eligible surviving spouse,
- anyone who is age 65 or enrolled in Medicare under age 65, or
- an employee whose address on file with ERS is outside of the United States.

Your covered dependents may also participate in the Secondary plan if:

- they are Medicare-eligible

If your dependent does not have Medicare, they may be eligible to participate in the HealthSelect of Texas[®] or HealthSelectSM Out-of-State plan, depending on where they live. Visit the ERS website at **www.ers.texas.gov** for more information on your plan eligibility.

Should I enroll in Medicare?

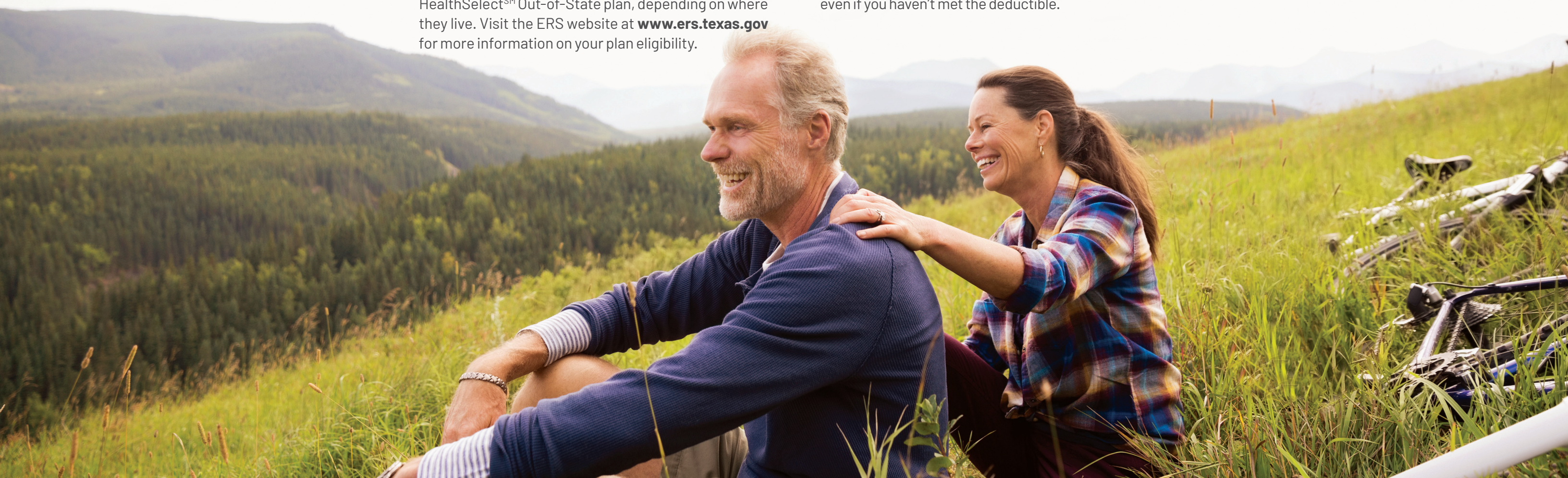
If you are eligible for Medicare, you should enroll in Medicare Part A and Medicare Part B. If you do not enroll when first eligible, you may pay more.

Things to know:

- Any copays or coinsurance you pay reduces both your Medicare and HealthSelect Secondary annual deductibles.
- you do not need to choose a primary care provider (PCP), although it is recommended.
- you do not need a referral from a PCP to see a specialist, and prior authorization is never required under this plan.
- preventive services — like annual check-ups and preventive vaccinations — are covered at 100% when you visit a provider who accepts Medicare, even if you haven't met the deductible.

We're here to help:

If you have any questions, call a BCBSTX Personal Health Assistant toll-free at **(800) 252-8039 (TTY: 711)**, Monday–Friday, 7 a.m. – 7 p.m. and Saturday, 7 a.m. – 3 p.m. CT. You can also refer to the HealthSelect Secondary Master Benefit Plan Document found on the “Publications, Forms and Presentations” page at **www.healthselectoftexas.com**.



SECONDARY BENEFITS CHART

Effective January 1, 2022

BENEFITS	HEALTHSELECT SECONDARY IN-NETWORK AND OUT-OF-NETWORK
Annual deductible	\$200 per individual, \$600 per family You must meet both your Medicare and your HealthSelect Secondary deductible(s) before this plan pays for covered services. Any copays or coinsurance you pay reduces both your Medicare and HealthSelect Secondary annual deductibles.
Out-of-network coverage?	Yes. Most services are covered at the same benefit levels as long as the provider accepts Medicare and this plan. See below for details.
Balance billing? (when an out-of-network provider charges you the difference between their billed charges and amount your plan allows)	Yes. Balance billing may apply to certain out-of-network services. When a service is not covered by Medicare or your Medicare benefits are exhausted, you could be balance-billed for non-emergency services from a non-network provider.
Total in-network out-of-pocket maximum (including deductibles, coinsurance and copays)	\$6,750 per person ¹ ; \$13,500 per family; Resets on Jan. 1
Out-of-pocket coinsurance maximum	\$3,000 per person; Resets on Jan. 1
Inpatient copay maximum	None
Primary care provider (PCP) required?	No
Referrals required?	No
Allergy treatment	\$0 copay / 30% coinsurance
Ambulance services (for emergencies)	\$0 copay / 30% coinsurance
Bariatric surgery	Not covered
Chiropractic care	\$0 copay / 30% coinsurance
Diabetes equipment ²	\$0 copay / 30% coinsurance
Diabetes supplies	\$0 copay / 30% coinsurance; Some supplies may be covered under the pharmacy plan benefits at \$0 cost to you.
Diagnostic X-rays and lab tests ⁶	\$0 copay / 30% coinsurance
Diagnostic mammography	\$0 copay; In-network diagnostic mammography is covered at no cost to participant(s)
Durable medical equipment ²	\$0 copay / 30% coinsurance
Facility-based providers (radiologists, pathologists and labs, anesthesiologists, emergency room physicians etc.)	\$0 copay / 30% coinsurance
Facility emergency care and hospital-affiliated freestanding emergency departments (not freestanding emergency room facilities)	\$0 copay / 30% coinsurance
Freestanding emergency room facility (FSER) ⁶	\$0 copay / 30% coinsurance
Habilitation and rehabilitation services - outpatient therapy (including physical therapy, occupational therapy and speech therapy)	\$0 copay / 30% coinsurance
Hearing aids (for covered participants over age 18)	\$0 copay; Up to \$1,000 per ear for any consecutive 36-month period and \$1 per battery. Annual HealthSelect Secondary deductible does not apply.
High-tech radiology (CT scan, MRI and nuclear medicine) ²	\$0 copay / 30% coinsurance
Home health care ²	\$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 ²	\$0 copay / 30% coinsurance; Annual HealthSelect deductible does not apply.
Inpatient hospital facility (semi-private room and day's board, and intensive care unit) ²	\$0 copay ⁵ / 30% coinsurance
Medications and injections administered by a provider (see below for outpatient medications and injections) ²	\$0 copay / 30% coinsurance Preventive vaccines are covered at 100%

BENEFITS	HEALTHSELECT SECONDARY IN-NETWORK AND OUT-OF-NETWORK
Office surgery and diagnostic procedures	\$0 copay / 30% coinsurance
PCP office visit	\$0 copay / 30% coinsurance
Private duty nursing ²	30% coinsurance; Unlimited hours
Retail health/convenience care clinic	\$0 copay / 30% coinsurance
Routine eye exam	30% coinsurance; limited to one exam per calendar year
Routine hearing test	30% coinsurance
Routine preventive care	No cost to participant(s)*
Skilled nursing facility (SNF)/inpatient rehabilitation facility services ²	No cost to participant(s); Annual HealthSelect deductible does not apply
Specialist physician office visit	\$0 copay / 30% coinsurance
Surgery (outpatient) other than in physician's office ²	\$0 copay / 30% coinsurance
Telemedicine visit ^{6,7}	\$0 copay / 30% coinsurance
Therapeutic treatments - outpatient	\$0 copay / 30% coinsurance
Urgent care clinic ⁶	\$0 copay / 30% coinsurance
Virtual Visits (mental health) ⁷	Doctor on Demand or MDLIVE covered at no cost to participant(s). Other providers not covered.
Mental Health Benefits – Member’s Share of Costs (Benefits apply to all covered mental health and behavioral health services, including serious mental illness treatment, substance abuse treatment, autism spectrum disorder services, etc.)	
Inpatient hospital mental health stay ²	\$0 copay ⁵ / 30% coinsurance
Mental health telemedicine ⁷	\$0 copay / 30% coinsurance
Outpatient facility care (partial hospitalization/day treatment and extensive outpatient treatment) ²	\$0 copay / 30% coinsurance
Outpatient physician or mental health provider office visit	\$0 copay / 30% coinsurance
Virtual Visits (mental health) ⁷	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. Some age requirements may apply. ¹ Includes medical and prescription drug copays, coinsurance and deductibles. Excludes non-network and non-covered services. ² Preauthorization may be required. ³ 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. ⁴ Copayment amount depends on whether treatment is provided by a PCP or specialist. ⁵ 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); you may be responsible for copay(s) and/or a coinsurance. Please see your Evidence of Coverage or Master Benefit Plan Document (MBPD) for more information. ⁶ Certain services related to COVID-19 testing may be covered by Medicare and your health plan at \$0 cost share during the Public Health Emergency. For information on what Medicare pays, visit https://www.medicare.gov/medicare-coronavirus . You may also contact your health plan by calling the number on the back of your medical ID card. ⁷ Your health plan may have reduced your cost share for certain services (such as non-COVID-19 related telemedicine and virtual visits) that is not mandated by the Family First Coronavirus Response Act for a period of time due to the coronavirus pandemic. Contact your health plan for additional information by calling the number on the back of your medical ID card.	

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