ERS®
Employees Retirement System of Texas

HEALTH PLANS COMPARISON CHART
EMPLOYEES AND RETIREES NOT ELIGIBLE FOR MEDICARE
EFFECTIVE SEPTEMBER 1, 2025

This chart shows your share of costs for commonly used medical, mental health, prescription drug and diabetes supply benefits in the HealthSelect of Texas® and Consumer Directed HealthSelect℠ plans. For in-depth information about eligibility, services that are covered and not covered, and how benefits are paid, view the Master Benefit Plan Documents (MBPD) on your plan's website. If there is a conflict between the MBPD, MBPD Amendments and this chart, the MBPD and its Amendments will control.

Blue Cross and Blue Shield of Texas (BCBSTX) administers medical and mental health benefits in the plans. Express Scripts manages prescription drug benefits for the plans. As administrators, they process claims and oversee the provider networks and drug formularies. ERS designs the benefits and pays the claims.

	HealthSelect of Texas®		Consumer Directed HealthSelect℠	
	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 Health Plan In-Network**	**Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network**
Administrator	**Blue Cross and Blue Shield of Texas (BCBSTX)**			
Annual deductible	None	$500 per individual $1,500 per family	$2,100 per individual, $4,200 per family To help cover part of the deductible, the State contributes to an eligible participant's health savings account: $540/year for an individual, $1,080/year for a family	$4,200 per individual, $8,400 per family To help cover part of the deductible, the State contributes to an eligible participant's health savings account: $540/year for an individual, $1,080/year for a family
Out-of-network benefits?		Yes. See next page for details.		Yes. See next page for details.
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-of-network services. For more information, see the plan's Master Benefit Plan Document.
Total in-network out-of-pocket maximum (including deductibles, coinsurance and copays)[1]	Jan. 1 – Dec. 31, 2025: $8,050 per person; $16,100 per family Jan.1 - Dec.31, 2026: $8,300 per person $16,600 per family		Jan. 1 – Dec. 31, 2025: $8,050 per person; $16,100 per family Jan.1 - Dec.31, 2026: $8,300 per person $16,600 per family	
Out-of-pocket coinsurance maximum	$2,000 per person	$7,000 per person	None	None
Inpatient copay maximum	$750 copay max, up to 5 days per hospital stay $2,250 copay max per calendar year per person		None	None
Primary care provider (PCP) required?	Participants who live and work in Texas: Yes Out-of-state participants: No	No	No	No
Referrals required?	Participants who live and work in Texas: Yes Participants who live out of state: No	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.

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

Health Plan Benefits

Service	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 Health Plan In-Network	Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network
Allergy treatment	Covered at 100% if administered in a physician's office; 20% coinsurance in any other outpatient location	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Ambulance services (for emergencies)	20% coinsurance	20% coinsurance; annual deductible does not apply	20% coinsurance after annual deductible is met	20% coinsurance after annual in-network deductible is met
Ambulance services (non-emergencies*)	20% coinsurance	20% coinsurance; annual deductible does not apply	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Applied Behavioral Analysis (ABA) treatment*	Coverage is based on place of treatment. • $25 copay if administered in a mental health provider's office • 20% coinsurance for any other outpatient location, including the home	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Bariatric surgery* Additional eligibility requirements apply. See the MBPD for details.	• Deductible: $5,000 • Coinsurance: 20% • Lifetime max: $13,000	Not covered	Not covered	Not covered
Chiropractic care	• Without office visit: 20% coinsurance • With office visit: $40 copay plus 20% coinsurance • Maximum benefits of $75 per visit and maximum of 30 visits per calendar year	40% coinsurance after annual deductible is met. Maximum benefits of $75 per visit and maximum of 30 visits per calendar year	20% coinsurance after annual deductible is met. Maximum benefits of $75 per visit and maximum of 30 visits per calendar year	40% coinsurance after annual deductible is met. Maximum benefits of $75 per visit and maximum of 30 visits per calendar year
Cranial hair prosthetics (wigs)	20% coinsurance; limited to lifetime benefit max of $1,000. Out-of-network deductible does not apply.		20% coinsurance after annual deductible is met; limited to lifetime benefit max of $1,000.	
Diagnostic A1c testing (for participants diagnosed with diabetes)	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance; deductible does not apply	40% coinsurance after annual deductible is met
Diabetes equipment	20% coinsurance; see page 6 for details.	40% coinsurance after annual deductible is met; see page 6 for details.	20% coinsurance after annual deductible is met; see page 6 for details.	40% coinsurance after annual deductible is met; see page 6 for details.
Diabetes supplies	See page 6 for details.			
Diagnostic X-rays and lab tests	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Diagnostic mammography	Covered at 100%	40% coinsurance after annual deductible is met	Covered at 100%; subsequent scans after breast cancer is established are covered at 100% after annual deductible is met	40% coinsurance after annual deductible is met
Durable medical equipment	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Facility-based providers (radiologists, pathologists and labs, anesthesiologists, emergency room physicians, etc.)	20% coinsurance	Emergencies: 20% coinsurance; annual deductible does not apply. Non-emergencies: 40% coinsurance after annual deductible is met (Network benefits apply to services rendered by an out-of-network provider in a network facility.)	20% coinsurance after annual deductible is met	Emergencies: 20% coinsurance after annual in-network deductible is met. Non-emergencies: 40% coinsurance after annual out-of-network deductible is met. (Network benefits apply to services rendered by an out-of-network provider in a network facility.)

*It is recommended your provider submit a request to BCBSTX to confirm coverage, limitations and medical necessity prior to rendering services.

Service	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 Health Plan In-Network	Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network
Facility emergency care (non-FSER) and hospital-affiliated freestanding emergency departments	$150 copay plus 20% coinsurance (If admitted, copay will apply to hospital copay.)	Emergencies: $150 copay plus 20% coinsurance (If admitted, copay will apply to hospital copay.) Annual deductible does not apply. Non-emergencies: $150 copay plus 40% coinsurance after annual out-of-network deductible is met.	20% coinsurance after annual deductible is met	Emergencies: 20% coinsurance after annual in-network deductible is met. Non-emergencies: 40% coinsurance after annual out-of-network deductible is met.
Freestanding emergency room facility	$150 copay plus 20% coinsurance	Emergencies: $150 copay plus 20% coinsurance; annual deductible does not apply. Non-emergencies: $150 copay plus 40% coinsurance after annual out-of-network deductible is met.	20% coinsurance after annual deductible is met	Emergencies: 20% coinsurance after annual in-network deductible is met. Non-emergencies: 40% coinsurance after annual out-of-network deductible is met.
Habilitation and rehabilitation services - outpatient therapy (including physical therapy, occupational therapy and speech therapy)	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Hearing aids (for covered participants over age 18)	Plan pays up to $1,000 per ear for any consecutive 36-month period and $1 per battery. In-network and out-of-network hearing aids are covered at the same benefit level.		20% coinsurance after annual in-network deductible is met. Plan pays up to $1,000 per ear for any consecutive 36-month period and $1 per battery. In-network and out-of-network hearing aids are covered a the same benefit level.	
Hearing aids (for participants 18 years of age and younger)	Plan pays 100%; limit of one hearing aid per ear for any consecutive 36-month period and $1 per battery. In-network and out-of-network hearing aids are covered at the same benefit level.		20% coinsurance after annual in-network deductible is met; limit of one hearing aid per ear per any consecutive 36-month period and $1 per battery. In-network and out-of-network hearing aids are covered at the same benefit level.	
High-tech radiology (CT scan, MRI and nuclear medicine)*	$100 copay plus 20% coinsurance	$100 copay plus 40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Home health care*	20% coinsurance	40% coinsurance after annual deductible is met Maximum 100 visits per calendar year (for out-of-network only)	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met. Maximum 100 visits per calendar year
Inpatient* and outpatient hospice and rehabilitation	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Inpatient hospital facility (medical and mental health semi-private room and day's board, and intensive care unit)*	• $150/day copay plus 20% coinsurance • $750 copay max, up to 5 days per hospital stay • $2,250 copay max per calendar year per person	• $150/day copay plus 40% coinsurance after annual deductible is met. • $750 copay max, up to 5 days per hospital stay • $2,250 copay max per calendar year per person	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Maternity care doctor charges only; inpatient hospital copays will apply	$25 or $40 copay for the visit to confirm pregnancy. No cost for subsequent routine prenatal, postnatal visits and obstetrician delivery services.	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met for the visit to confirm pregnancy. No cost for subsequent routine prenatal, postnatal visits and obstetrician delivery services.	40% coinsurance after annual deductible is met

*It is recommended that your provider submit a request to BCBSTX to confirm coverage, limits and medical necessity prior to rendering services.

Service	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 Health Plan In-Network	Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network
Medications and injections administered by a provider (including specialty medications obtained through BCBSTX*)	• Physician's office: Covered at 100% after copay (or 100% if no charge is assessed for office visit) • Any other outpatient location: 20% coinsurance. • Preventive vaccines covered at 100%	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met Preventive vaccines covered at 100%	40% coinsurance after annual deductible is met
Mental health provider office visit	$25 copay	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Outpatient facility care (includes mental health partial hospitalization/ day treatment and extensive outpatient treatment*)	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
PCP office visit	$25 copay	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Private duty nursing*	20% coinsurance	40% coinsurance after annual deductible is met Maximum of 96 hours per calendar year	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met Maximum of 96 hours per calendar year
Retail health/ convenience care clinic	$25 copay	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Routine eye exam, one per year per participant	$40 copay	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Routine preventive care	No cost to participant(s)	40% coinsurance after annual deductible is met	No cost to participant(s)	40% coinsurance after annual deductible is met
Skilled nursing facility/inpatient rehabilitation facility services*	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Specialist physician office visit (non-mental health)	$40 copay with valid PCP referral on file	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Surgery in a physician's office	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Surgery (outpatient) other than in physician's office*	$100 copay plus 20% coinsurance	$100 copay plus 40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Telemedicine visit	Coverage is based on place of treatment billed. • Provider's office: $25/$40 copay for physician's office visit • Any other outpatient telemedicine: 20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Therapeutic treatments - outpatient	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Urgent care clinic	$50 copay plus 20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Virtual Visits (medical and mental health)	$0 copay for virtual visits when provided by Doctor On Demand® or MDLIVE®	Not covered	20% coinsurance after annual deductible is met for virtual visits when provided by Doctor On Demand or MDLIVE	Not covered

*It is recommended your provider submit a request to BCBSTX to confirm coverage, limitations and medical necessity prior to rendering services

Prescription Drug Benefits

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 (network or out-of-network), Extended Day Supply Pharmacy (EDS) or mail service pharmacy.

You will pay less for your drugs when you fill your prescription at a network pharmacy. The Express Scripts network includes thousands of retail locations, including national chains and many community pharmacies. To find a network pharmacy near you, use the Find a Pharmacy tool at **www.HealthSelectRx.com** or call an Express Scripts customer care representative toll-free at **(800) 935-7189 (TTY: 711)**.

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.

	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 Health Plan In-Network	Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network
Pharmacy benefits manager (PBM)	Express Scripts			
Out-of-network benefits?		Yes		Yes
Deductible	$50 prescription drug deductible per participant per calendar year applies before the plan pays for any prescription drugs (except covered preventive medications, specific diabetic supplies (as listed on page 6) and insulin dispensed by an in-network pharmacy).		$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.
Tier 1 (mostly generic drugs)	Non-maintenance and maintenance (30 days' supply): $10 copay Mail order or extended day supply pharmacy (90 days' supply): $30 copay	Non-maintenance and maintenance (30 days' supply): $10 copay plus 40% coinsurance Mail order or extended day supply pharmacy (90 days' supply): $30 copay plus 40% coinsurance	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Tier 2 (mostly preferred brand name drugs)*	• Non-maintenance (30 days' supply): $35 copay • Maintenance (30 days' supply): $45 copay • Mail order or extended day supply pharmacy (90 days' supply): $105 copay	• Non-maintenance (30 days' supply): $35 copay plus 40% coinsurance • Maintenance (30 days' supply): $45 copay plus 40% coinsurance • Mail order or extended day supply (90 days' supply): $105 copay plus 40% coinsurance	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Tier 3 (mostly non-preferred brand name drugs)*	• Non-maintenance (30 days' supply): $60 copay • Maintenance (30 days' supply): $75 copay • Mail order or extended day supply pharmacy (90 days' supply): $180 copay	• Non-maintenance (30 days' supply): $60 copay plus 40% coinsurance • Maintenance (30 days' supply): $75 copay plus 40% coinsurance • Mail order or extended day supply pharmacy (90 days' supply): $180 copay plus 40% coinsurance	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Specialty drugs*	If purchased through a pharmacy, specialty drugs are covered at the specific tier level (generic, preferred or non-preferred) as listed above. Otherwise, they are covered as a medical benefit.		20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met

*Prior Authorization 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 prescription drug benefits or for help finding an in-network pharmacy, contact HealthSelect PDP customer care toll-free at **(800) 935-7189 (TTY: 711)**. For more information on your medical plan benefits, contact a BCBSTX Personal Health Assistant toll-free at **(800) 252-8039 (TTY: 711)**. To see if any other programs for diabetic supplies and equipment may be available to you, see your health plan's Master Benefit Plan Document.

	HealthSelect of Texas® and HealthSelect℠ Out-of-State		Consumer Directed HealthSelect℠	
	Prescription Drug Program (PDP) benefits	**Medical plan benefits**	**Prescription Drug Program (PDP) benefits**	**Medical plan benefits**
Diabetes equipment - glucometers	Certain brands of preferred glucometers are covered at no cost to participants when received through the free glucometer program*. For more information on the free glucometer program, call Express Scripts.	Refer to Prescription Drug Program (PDP) benefits	Certain brands of preferred glucometers are covered at no cost to participants when received through the free glucometer program*. For more information on the free glucometer program, call Express Scripts.	Refer to Prescription Drug Program (PDP) benefits
Diabetes equipment - Continuous glucose monitors / insulin pumps	Certain brands of continuous glucose monitors and related supplies	20% coinsurance for in-network and 40% coinsurance for out-of-network covered continuous glucose monitors and insulin pumps through durable medical equipment benefits.	Certain brands of continuous glucose monitors and related supplies	20% coinsurance for in-network and 40% coinsurance for out-of-network covered continuous glucose monitors and insulin pumps through durable medical equipment benefits.
Diabetic supplies	Certain brands of preferred diabetic test strips* are covered at no cost to participants when purchased from a PDP in-network pharmacy. Lancets and lancing devices, and syringes are covered at no cost to participants when purchased from a PDP in-network pharmacy.	20% coinsurance for in-network and out-of-network diabetic supplies used exclusively with a provider prescribed continuous glucose monitor or insulin pump. For all other diabetic supplies, refer to PDP benefits.	20% coinsurance for covered diabetic supplies after annual in-network deductible is met when purchased from a PDP in-network pharmacy 40% coinsurance after annual out-of-network deductible is met when purchased from a PDP out-of-network pharmacy	20% coinsurance for in-network and out-of-network diabetic supplies used exclusively with a provider prescribed continuous glucose monitor or insulin pump. For all other diabetic supplies, refer to PDP benefits.
Prescription insulin	In-network pharmacy: Insulin products on the PDP drug list (formulary) are covered with a maximum $25 copay per 30-day supply, regardless of tier. Out-of-network pharmacy: Insulin products are covered at a Tier 1, Tier 2 or Tier 3 copay and 40% coinsurance.	Not covered under medical plan benefits	In-network pharmacy: 20% coinsurance (up to $25 maximum per 30-day supply) for insulin products on the PDP drug list (formulary) Out-of-network pharmacy: 40% coinsurance for insulin products after annual out-of-network deductible is met	Not covered under medical plan benefits

*Benefits and covered brands of glucometers and test strips are subject to change.