

MEDICARE HEALTH PLANS COMPARISON CHART

The plan year for HealthSelect Medicare AdvantageSM and KelseyCare Advantage HMO is January 1 to December 31.
The plan year for the other plans is September 1 to August 31.

This chart is intended to provide a general comparison of Texas Employees Group Benefits Program (GBP) benefits and is subject to change. Please see your Summary of Benefits for more detailed information.

| Benefit | Original Medicare ⁴ (Medicare rates are subject to change) | HealthSelect Medicare Advantage Plan SM (No coordination with Medicare is necessary) | Medicare Primary, HealthSelect Secondary (HealthSelect and Medicare coordinate benefits for you) | Medicare Primary, GBP HMO Secondary (GBP HMO plans coordinate benefits with Medicare for you) | | KelseyCare Advantage HMO (No coordination with Medicare is necessary) |
|---|--|--|---|--|--|--|
| | | | | Community First, Scott & White | KelseyCare powered by Community | |
| Calendar year deductible | \$147 | None | \$200 per individual \$600 per family | None | None | None |
| Office visits in conjunction with an illness or injury | 20% | \$0 | \$0 copay / 30% ^{4,7} coinsurance | \$0 copay / \$25 ⁷ copay | \$0 copay / \$15 ⁷ copay | \$0 |
| Specialty physician office visit | 20% | \$0 | \$0 copay / 30% ^{4,7} coinsurance | \$0 copay / \$40 ⁷ copay | \$0 copay / \$25 ⁷ copay | \$0 |
| Diagnostic tests and x-rays, including allergy testing | 20% | \$0 | \$0 copay / 30% ^{4,7} coinsurance | \$0 copay / 20% ⁷ coinsurance | \$0 copay for diagnostic tests / x-rays. Allergy testing: \$15 PCP or \$25 specialist copay ^{6,7} | \$0 |
| Diagnostic mammography | \$0 | \$0 | \$0 copay / 30% ^{4,7} coinsurance | \$0 copay / 20% ⁷ coinsurance | \$0 copay ⁷ | \$0 |
| Diagnostic lab services | \$0 | \$0 | \$0 copay / 30% ^{4,7} coinsurance | \$0 copay / 20% ⁷ coinsurance | \$0 copay ⁷ | \$0 |
| Preventive services (such as screening mammogram, physical, well woman exam, prostate cancer screening, etc.) | \$0 ^{1,3} Does not cover lab tests | \$0 ^{1,3} Covers screening lab tests | \$0 ¹ | \$0 ¹ | \$0 ¹ | \$0 ^{1,3} |
| Mental health and substance use disorder | | | | | | |
| a. Outpatient physician or mental health provider office visits | | \$0 | \$0 copay / 30% ^{4,7} coinsurance | \$25 | \$25 | \$0 |
| b. Hospital—Inpatient stay (semi-private room and days board, and intensive care unit) | | \$0 per admission | \$0 ⁸ If provider doesn't accept Part A, then coverage is \$150 copay/day up to \$750 per admission and \$2,250 per Calendar Year. 30% ^{4,7} after copay | 20% coinsurance (plus \$150 a day copay per admission) | 20% coinsurance (plus \$150 a day copay per admission) | \$0 |
| c. Outpatient facility care (partial hospitalization/ day treatment and extensive outpatient treatment) | | \$0 | \$0 copay / 30% ^{4,7} coinsurance | \$25 copay (prior authorization required) | \$25 copay | \$0 |
| Office surgery and diagnostic procedures | 20% | \$0 | \$0 copay / 30% ^{4,7} coinsurance | Community First: 20% coinsurance ⁷ Scott&White: \$20 ⁷ | \$0 / \$15 PCP or \$25 specialist copay ^{6,7} | \$0 |
| Immunizations* | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| High-tech radiology (CT scan, MRI, nuclear medicine) | 20% | \$0 | \$0 copay / 30% ^{4,7} coinsurance | \$0 copay / \$100 ⁷ copay plus 20% | \$150 ⁷ copay/scan type/ day | \$0 |
| Allergy injections and serum | 20% | \$0 | \$0 copay / 30% ^{4,7} coinsurance | \$0 copay / 20% ⁷ coinsurance | Allergy Serum: \$0 Without office visit: \$0 With office visit: \$15 PCP or \$25 specialist copay ^{6,7} | \$0 |
| Routine eye exam | Does not cover | \$0 ¹ | 30% ^{1,4} | \$40 copay ² | \$25 copay ² | \$0 ¹ |

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|---|---|---|---|---|---|---|
| | | | | Community First, Scott & White | KelseyCare powered by Community | |
| Vision (Contact lens fitting exams are not covered) | Frames: You pay 100% for non-covered services 20% for one pair of eyeglasses after each cataract surgery with an intraocular lens. | \$0 for one pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. | Frames: Does not cover | Community First: Does not cover Scott & White: Does not cover | Does not cover | \$150 plan coverage limit for eyewear, glasses, and/or contact lenses every two years unrelated to post-cataract surgery. ¹⁰ Allowance can only be used on date of service. |
| | Contacts: You pay 100% for non-covered services 20% for one set of contact lenses after each cataract surgery with an intraocular lens. | \$0 for one pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. | Contacts: Does not cover | Community First: You receive a \$125 allowance every 2 years in lieu of glasses ⁹ Scott & White: Does not cover | Does not cover | |
| Routine hearing test | Does not cover | Does not cover | 30% ⁴ | Without office visit: 20% coinsurance, With office visit: \$40 copay plus 20% coinsurance | Without office visit: 20% coinsurance, With office visit: \$25 copay plus 20% coinsurance | \$0 copay for up to one supplemental routine hearing exam every year ^{1,2} |
| Diagnostic speech and hearing testing | 20% | \$0 | \$0 copay / 30% ^{4,7} coinsurance | Without office visit: \$0 copay / 20% ⁷ coinsurance With office visit: \$0 copay / \$40 copay ⁷ plus 20% coinsurance | Without office visit: \$0 copay / 20% ⁷ coinsurance With office visit: \$0 copay / \$25 copay ⁷ plus 20% coinsurance | \$0 for Medicare-covered diagnostic hearing exams |
| Speech and hearing therapy | 20% | \$0 | \$0 copay / 30% ^{4,7} coinsurance | Without office visit: \$0 copay / 20% ⁷ coinsurance With office visit: \$0 copay / \$40 copay ⁷ plus 20% coinsurance | Without office visit: \$0 copay / 20% ⁷ coinsurance With office visit: \$0 copay / \$25 copay ⁷ plus 20% coinsurance | \$0 |
| Hearing aids | Does not cover | \$1,000 benefit allowance per ear every 3 years | \$1,000 benefit allowance per ear every 3 years | \$1,000 benefit allowance per ear every 3 years (Repairs not covered) | \$1,000 benefit allowance per ear every 3 years (Repairs not covered) | \$1,500 plan coverage limit for hearing aids every 2 years (Does not include battery replacement) \$0 copayment for up to one hearing aid fitting/evaluation every 2 years ² |
| Chiropractic care | 20% for Medicare-covered chiropractic services | 30% for specialist office visit for routine services, up to a maximum of a \$75 benefit per visit. Benefit is limited to 30 visits per plan year. | \$0 copay / 30% ^{4,7} coinsurance | Community First: \$0 copay / \$40 copay ⁷ Benefit is limited to 30 visits per plan year. Scott&White: Without office visit: 20%; with office visit: \$40 plus 20% ⁷ . Benefit is limited to 35 visits per calendar year; 5 per month | \$0 copay / \$25 copay ⁷ Benefit is limited to 30 visits per calendar year. | \$0 for each Medicare-covered visit |
| Urgent care clinic | 20% | \$0 | \$0 copay / 30% ^{4,7} coinsurance | \$0 copay / \$50 copay ⁷ + 20% coinsurance | \$0 copay / \$50 copay ⁷ + 20% coinsurance | \$0 |
| Emergency room care | 20% Plus emergency room copay (waived if admitted to hospital within 3 days of emergency room visit) | <ul style="list-style-type: none"> In U.S.: \$0 Outside U.S. and Puerto Rico: 20% after \$100 deductible. Limited to \$25,000 per plan year or 60 consecutive days, whichever is greater. | \$0 copay/30% ^{4,7} coinsurance | \$0 copay / \$150 copay ⁷ plus 20% In area and out-of-area covered at listed copayment | \$0 copay / \$150 copay ⁷ plus 20% In area and out-of-area covered at listed copayment | <ul style="list-style-type: none"> In U.S.: \$0 Outside U.S.: 20% after \$250 deductible |

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|--|--|---|---|--|--|---|
| | | | | Community First, Scott & White | KelseyCare powered by Community | |
| Inpatient hospital (semi-private room and days board, and intensive care unit) | \$0 after the following amounts for each benefit period ⁵ : <ul style="list-style-type: none"> \$1,184 deductible for days 1-60; \$296 copay per day (days 61-90); \$592 copay per lifetime reserve day (days 91-150) | \$0 | \$0 ⁸ If provider doesn't accept Part A, then coverage is \$150 copay/day up to \$750 per admission and \$2,250 per Calendar Year. 30% ^{4,7} after copay | \$0 ⁸ If provider doesn't accept Part A, then coverage is \$150 copay/day up to \$750 per admission and \$2,250 per Calendar Year. 20% after copay | \$0 ⁸ If provider doesn't accept Part A, then coverage is \$150 copay/day up to \$750 per admission and \$2,250 per Calendar Year. 20% after copay | \$0 No limit to the number of days covered by the plan each benefit period ⁵ |
| Outpatient surgery | 20% Specified copay for outpatient hospital facility charges | \$0 | \$0 or \$100 copay – plus 30% ^{4,7} coinsurance | \$0 copay / \$100 copay ⁷ plus 20% | \$150 copay ⁷ | \$0 |
| Skilled nursing facility | <ul style="list-style-type: none"> Days 1-20: \$0 (3-day hospital stay required); Days 21-100: \$141.50 coinsurance per day Per benefit period⁵ | <ul style="list-style-type: none"> \$0 up to 100 days per benefit period (no 3-day hospital stay is required) You pay 100% after 100 days | <ul style="list-style-type: none"> No deductible Plan pays 100% | \$0 copay / 20% ⁷ coinsurance | \$0 copay / 20% ⁷ coinsurance | <ul style="list-style-type: none"> Days 1-100: \$0 copayment per day Plan covers up to 100 days each benefit period⁵ No prior hospital stay is required |
| Home health care | \$0 | \$0 | \$0 copay/30% ^{4,7} coinsurance for home infusion therapy Plan pays 100% for all other home health care services with a maximum of 100 visits per calendar year | \$0 copay / 20% ⁷ coinsurance | \$0 copay / 20% ⁷ coinsurance | \$0 |
| Hospice | <ul style="list-style-type: none"> 5% of the Medicare-approved amount for inpatient respite care \$5 copay for pain management drugs | Same benefits as under Original Medicare | \$0 copay / 30% ^{4,7} coinsurance | \$0 copay / 20% ⁷ coinsurance | \$0 copay / 20% ⁷ coinsurance | <ul style="list-style-type: none"> Same benefits as under Original Medicare You must receive care from a Medicare-certified hospice |
| Ambulance | 20% | \$0 | \$0 copay/30% ^{4,7} coinsurance Emergency care only. Not applicable to non-emergent transportation services. | \$0 copay / 20% ⁷ coinsurance | \$0 copay / 20% ⁷ coinsurance | \$0 |
| Private duty nursing | Does not cover | 30% Pays a maximum benefit of \$8,000 per calendar year | 30% ⁴ <ul style="list-style-type: none"> Unlimited hours Preauthorization is required | \$0 copay / 20% ⁷ coinsurance | \$0 copay / 20% ⁷ coinsurance | Does not cover |

*Under the Affordable Care Act, certain preventive health and women's services are paid at 100% (at no cost to the member) 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 One per calendar year.

² One per plan year.

³ No copayment for a pap smear once every 24 months; once every 12 months for those at high risk.

⁴ After payment of deductible. HealthSelect note: Medicare and HealthSelect deductibles run concurrently. Member may be responsible for some charges when the provider does not accept Medicare assignment.

⁵ 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.

⁶ Copayment amount depends on whether treatment is provided by a PCP or specialist.

⁷ Payment amount is dependent upon the coordination of benefits (COB) between your carrier (HealthSelect, Community First, KelseyCare powered by Community Health Choice, Scott & White) and Original Medicare. Sometimes this means your expense is \$0, but charges will vary depending upon COB. Please reference your Summary of Benefits for more information.

⁸ 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 COB), you may be responsible for copay(s) and/or a coinsurance. Please see your Summary of Benefits for more information.

⁹ ERS cannot and does not guarantee the length of time that a specific type of "Value-Added" product shall be offered. Any questions or concerns about these products should be directed to your carrier.

¹⁰ Does not count toward out-of-pocket maximum.

How much does it cost?

Premiums for ERS Medicare Advantage plans are much lower than what you're paying now to cover a Medicare-eligible dependent. You must continue paying Medicare Part B premiums with all health plans.

Plan Year 2017 (effective until December 31, 2017)

| Coverage level* | HealthSelect Medicare Advantage Premium | HealthSelect of Texas Premium | Your savings with HealthSelect Medicare Advantage | KelseyCare Medicare Advantage premium | Your savings with KelseyCare Medicare Advantage |
|-----------------------------|---|-------------------------------|---|---------------------------------------|---|
| | PY2017 | PY2017 | PY2017 | PY2017 | PY2017 |
| Retiree only | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 |
| Retiree & spouse | \$157.08 | \$353.68 | \$196.60 | \$131.84 | \$221.84 |
| Retiree & children | \$157.08 | \$236.80 | \$79.72 | \$131.84 | \$104.96 |
| Retiree & family | \$314.16 | \$590.48 | \$276.32 | \$263.68 | \$326.80 |
| Surviving spouse only | \$314.16 | \$707.36 | \$393.20 | \$263.68 | \$443.68 |
| Surviving children only | \$314.16 | \$473.60 | \$159.44 | \$263.68 | \$209.92 |
| Surviving spouse & children | \$628.32 | \$1,180.96 | \$552.64 | \$527.36 | \$653.60 |

| Plan Name | Plan Administrator | Prescription Drug | Description |
|--|--|---|---|
| HealthSelect Medicare AdvantageSM  | Humana (855) 377-0001 | HealthSelect Medicare Rx through UnitedHealthcare (from January 1, 2017)  | Humana administers your Medicare; doctors and other providers file one claim with Humana. |
| HealthSelectSM of Texas (HealthSelect Secondary)  | UnitedHealthcare (866) 336-9371 | HealthSelect Medicare Rx through OptumRx (from January 1, 2017)  | Medicare pays primary and HealthSelect pays secondary. |
| KelseyCare Advantage HMO  | KelseyCare Advantage (Houston area) (877) 853-9075 | HealthSelect Medicare Rx through UnitedHealthcare (from January 1, 2017)  | KelseyCare Advantage administers your Medicare; doctors and other providers file one claim with KelseyCare Advantage. (available only to members in the Houston area) |
| Scott & White Health Plan (HMO)  | Scott & White (Central Texas) (800) 321-7947 | Argus Health | Medicare pays primary and HMO pays secondary. (available only to members in the Central Texas area) |
| Community First Health Plans (HMO)  | Community First (San Antonio area) (877) 698-7032 | Navitus Health Solutions | Medicare pays primary and HMO pays secondary. (available only to members in the San Antonio area) |
| KelseyCare powered by Community Health Choice (HMO)  | KelseyCare powered by Community Health Choice (Houston area) (844) 515-4877 | Navitus Health Solutions | Medicare pays primary and HMO pays secondary. (available only to members in the Houston area) |