

HEALTH PLANS COMPARISON CHART

EMPLOYEES AND RETIREES NOT ELIGIBLE FOR MEDICARE

EFFECTIVE SEPTEMBER 1, 2026

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 HealthSelectSM 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 SM Out-of-State In-Network	HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network	Consumer Directed HealthSelect SM 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, 2026: \$8,300 per person; \$16,600 per family Jan. 1 - Dec.31, 2027: \$8,600 per person \$17,000 per family		Jan. 1 – Dec. 31, 2026: \$8,300 per person; \$16,600 per family Jan.1 - Dec.31, 2027: \$8,600 per person \$17,000 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.

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

Health Plan Benefits

Service	HealthSelect of Texas® and HealthSelect SM Out-of-State In-Network	HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network	Consumer Directed HealthSelect SM 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 SM Out-of-State In-Network	HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network	Consumer Directed HealthSelect SM 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 at 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, 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, 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
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

*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 SM Out-of-State In-Network	HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network	Consumer Directed HealthSelect SM High-deductible Health Plan In-Network	Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network
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 SM Out-of-State In-Network	HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network	Consumer Directed HealthSelect SM 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 SM Out-of-State		Consumer Directed HealthSelect SM	
	Prescription Drug Program (PDP) benefits	Medical plan benefits	Prescription Drug Program (PDP) benefits	Medical plan benefits
Diabetes equipment - glucose meters	Certain brands of preferred glucose meters are covered at no cost to participants when received through the free glucose meters program*. For more information on the free glucose meters program, call Express Scripts.	Refer to Prescription Drug Program (PDP) benefits	Certain brands of preferred glucose meters are covered at no cost to participants when received through the free glucose meters program*. For more information on the free glucose meters 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	Covered continuous glucose monitors and insulin pumps through durable medical equipment benefits: In-Network - 20% coinsurance Out-of-Network - 40% coinsurance after annual deductible is met.	Certain brands of continuous glucose monitors and related supplies	Covered continuous glucose monitors and insulin pumps through durable medical equipment benefits: In-Network - 20% coinsurance after annual deductible is met Out-of-Network - 40% coinsurance after annual deductible is met
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.	Diabetic supplies used exclusively with a provider-prescribed continuous glucose monitor or insulin pump. In-Network - 20% coinsurance Out-of-Network - 40% coinsurance after annual deductible is met	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	Diabetic supplies used exclusively with a provider-prescribed continuous glucose monitor or insulin pump. In-Network - 20% coinsurance after annual deductible is met Out-of-Network - 40% coinsurance after annual deductible is met
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.

DENTAL INSURANCE AND COMPARISON CHART

Dental insurance

ERS offers two dental plans: **State of Texas Dental Choice Plan** (nationwide) and **HumanaDental DHMO** (only in Texas). Both plans are administered by Humana. You and your eligible dependents must be enrolled in the same plan; however, you can designate different primary care dentists.

Which plan works best for you?

We recommend reviewing each plan to see how it fits your family's needs. How often do you see the dentist? Are you or your dependent planning to see an orthodontist? If you're considering the dental health maintenance organization, is your preferred dentist in the service area? Review each of the plans before you make a decision. If you have questions, call Humana toll free at **(855) 756 - 6580 (TTY: 711)**.

	STATE OF TEXAS DENTAL CHOICE PLAN	Humana
	State of Texas Dental Choice PlanSM PPO This is a preferred provider organization (PPO) dental insurance plan.	HumanaDental DHMO This is a dental health maintenance organization (DHMO) insurance plan.
	Nationwide	Only in Texas
Where can I use this plan?	You can see any dentist in the U.S. but you generally pay less if you stay in the plan's network. For information about coverage available outside of the U.S., please see the master Benefit Plan Document at www.ERSdentalplans.com.	Coverage applies only to dentists in the Texas service area. Before you enroll, make sure there is a HumanaDental DHMO network dentist in your area.
Is a primary care dentist (PCD) required?	No , but you pay less if you use an in-network dentist.	Yes . Make sure there is a PCD in your area before enrolling in this plan. You and your enrolled dependents can choose different PCDs.
Deductible	Yes . The amount differs for in-network and out-of-network dentists.	No
Copays/coinsurance		Yes , depending on the service.

Do I need an ID card to see a dentist?

Participating Humana dentists shouldn't require them. If you would like a card, you can download a virtual ID card to your smartphone through the MyHumana mobile app. You can also download and print your ID information from **ERSdentalplans.com**.

Dental plans comparison chart

This chart is a summary of benefits in the two dental insurance plans. See plan booklets at ERSdentalplans.com for actual coverage and limitations. Humana administers both plans. Before starting treatment, discuss the treatment plan and all charges with your dentist.

	State of Texas Dental Choice Plan PPO – In-Network	State of Texas Dental Choice Plan PPO – Out-of-Network	HumanaDental DHMO (Services from participating PCDs only)
Dentists	In-network dentist	Out-of-network dentist	You must select a primary care dentist (PCD). NOTE: Not all in-network dentists accept new patients. Dentists are not required to stay in the network for the entire year.
Deductibles	Preventive: Individual-\$0; Family-\$0 Combined Basic/Major: Individual-\$50; Family-\$150 Orthodontic services: no deductible In State of Texas Dental Choice Plan, deductibles are based on the calendar year and reset on January 1.	Preventive: Individual-\$50; Family-\$150 Combined Basic/Major: Individual-\$100; Family-\$300 Orthodontic services: no deductible	None
Copays / coinsurance	Preventive and Diagnostic Services: none Basic Services: 10% coinsurance after meeting the basic services deductible Major Services: 50% coinsurance after meeting the major services deductible There is no charge for anything over the allowed amount. After reaching the maximum calendar year benefit, the participant pays 60% until January 1.	Preventive and Diagnostic Services: 10% coinsurance after meeting the preventive and diagnostic deductible Basic Services: 30% coinsurance after meeting the basic services deductible Major Services: 60% coinsurance after meeting the major services deductible Participants may be required to pay the difference between the allowed amount and billed charges. Once the maximum calendar year benefit is reached, the participant pays 100% until January 1.	Primary care dentist (PCD): Copays vary according to service and are listed in the “Schedule of Dental Benefits” booklet. Specialty dentistry: 75% of the dentist’s usual and customary fee when specialty care is coordinated by the PCD to a network specialist. Plan doesn’t pay.
Maximum calendar year benefits	\$2,000 per covered individual (includes orthodontic extractions) plus 40% after maximum calendar year benefit is met	Does not apply to orthodontic services provided by out-of-network dentists (plan pays \$0)	Unlimited
Maximum lifetime benefit	\$2,000 per covered individual for orthodontic services	\$2,000 per covered individual for orthodontic services	Unlimited
Average cost of cleaning / oral exams	Up to two cleaning/oral exams per calendar year allowed	10% of the allowed amount after deductible is met Up to two cleaning/oral exams per calendar year allowed	Vary according to service and are listed in the “Schedule of Dental Benefits” booklet Up to two cleaning/oral exams per calendar year allowed
Orthodontic coverage	50% of the allowed amount	50% of the allowed amount Participants may be required to pay the difference between the allowed amount and billed charges.	Orthodontic services performed by a participating general dentist are offered at the listed copayment amount. Orthodontic services performed by a participating specialist are offered at 75% of their usual and customary fee. Plan doesn’t pay.

VISION COMPARISON CHART



If you wear contacts or glasses, you can save money with State of Texas VisionSM. EyeMed Vision Care, LLC is the administrator of State of Texas Vision. Plan participants have access to EyeMed's INSIGHT network, which includes independent, national and regional retailers and online providers.

The State of Texas Vision covers one comprehensive eye exam at any time during the plan year (Sept. 1–Aug. 31); an annual \$200 retail allowance to use toward either eyeglass frames or contact lenses; and discounts for Lasik. Any dependent you enroll in this plan will receive each of these benefits.

Does the plan cover eye conditions like glaucoma or cataracts?

No. Only your HealthSelect health plan covers eye conditions, eye injuries and diseases. It also covers an annual eye exam, but doesn't cover glasses or contacts like State of Texas Vision.

If you have questions, visit StateofTexasVision.com or call (844) 949-2170 (TTY: 711).

Vision Comparison Chart

Vision Care Services	In-Network Member Cost	Out-of-Network Member Reimbursement
Exam Services		
Exam	\$15 copay ¹	Up to \$40 after \$15 copay
Contact Lens Fit and Follow-Up²		
Fit and Follow-up – Standard	\$25 copay ¹	Up to \$100
Fit and Follow-up – Premium	\$35 copay ¹	Up to \$100
Frame		
Frame	\$200 retail allowance; 20% off amount over \$200	Up to \$75
Lenses		
Single Vision	\$10 copay ¹	Up to \$30
Bifocal	\$15 copay ¹	Up to \$45
Trifocal	\$20 copay ¹	Up to \$60
Progressive – Standard³	\$70 copay plus bifocal \$15 ¹	Up to \$45
Lens Options		
Polycarbonate - Standard	\$40 copay ¹	Not covered
Scratch Coating - Standard Plastic	\$10 copay ¹	Not covered
Tint - Solid and/or Gradient	\$10 copay ¹	Not covered
UV Treatment	\$10 copay ¹	Not covered
Anti-Reflective Coating - Standard	\$40 copay ¹	Not covered
Contact Lenses		
Contacts - Elective	\$200 allowance	Up to \$200
Contacts - Medically Necessary	\$0 copay	Up to \$210
Other		
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call (800) 988-4221	Not covered
Retinal Imaging	You are responsible for 100% of the cost, which is up to \$39 for EyeMed customers.	Not covered

¹ Covered in full after copay is met.

² A Contact Lens Fit and Follow-Up has its own copay and is separate from the eye exam copay. Standard Contact Lens Fit and Follow-up applies to a current contact lens user who wears disposable, daily wear, or extended wear lenses only. Premium Contact Lens Fit and Follow-up applies to new contact wearers and/or a participant who wears toric, gas permeable, or multi-focal lenses.

³ Standard progressives are covered in full after a \$70 copay. The \$15 bifocal copay also applies to standard progressive lenses. For premium progressive lenses, the plan coverage is up to the in-network plan payment for standard progressive lenses.