

2021 Summer Enrollment Active Employee Guide

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Benefits to protect your health and future

As a State of Texas agency or higher education institution employee, you are eligible to participate in the Texas Employees Group Benefits Program (GBP), which provides valuable benefits for you and your family.

Summer Enrollment is your chance to review your benefits and make changes. It is the only time you can make benefit changes unless you have a qualifying life event during the plan year (see ers.texas.gov/Active-Employees/Life-Changes-for-active-employees).

You should take this opportunity to refresh your knowledge about your coverage options. Consider any life changes you've had in the past year and think about what medical, dental or vision care services you or your family members might need in Plan Year 2022. View more details and premium rate sheets at www.ers.texas.gov/SE.

This year, there's an important change for health maintenance organization (HMO) participants. Starting September 1, the Scott and White Care Plans (SWCP) and Community First Health Plans (CFHP) HMOs will no longer be offered through the GBP. Central Texas and San Antonio-area HMO participants will automatically move to HealthSelect of Texas[®] or have the option to enroll in Consumer Directed HealthSelectSM. Current HMO participants can also choose to waive GBP coverage or choose Health Insurance Opt-Out Credit (see page 7 for Health Insurance Opt-Out Credit).

Need to make changes to your benefits?

You should make any needed changes to your benefits during your assigned two-week Summer Enrollment phase.

Find the dates of your phase in the top left corner of your Personal Benefits Enrollment Statement, or go to www.ers.texas.gov/SE.

No changes? No action needed

If you wish to keep your same coverage, **you do not need to do anything**. Your benefits will stay the same. Benefit elections for the new plan year are effective September 1.

SUMMER ENROLLMENT WEBINARS

To ensure the health and safety of state employees and retirees during the COVID-19 pandemic, ERS and the Texas Employees Group Benefits Program (GBP) plan administrators are hosting several hour-long Summer Enrollment webinars instead of our traditional in-person fairs.

Participate in as many webinars as you wish from the convenience of your home or office. Q&A sessions led by plan administrators will feature a brief overview of the plans, followed by time for questions. (Plan representatives can answer general questions; if you have a specific question about your claim, contact the plan's customer service number.)

PLEASE NOTE: In rare cases, ERS must cancel or change events due to issues beyond our control. When possible, we will provide notice of cancellations and/or changes on the ERS website. If you're planning to join a webinar, check the Events webpage (www.ers.texas.gov/Event-Calendars) shortly before the event for any updates. Other webinars may be added. Visit the Summer Enrollment webpage at www.ers.texas.gov/SE to check for schedule updates and to access webinar recordings.

ERS Summer Enrollment webinars

Register at www.ers.texas.gov/Event-Calendars.

Topic	Presenter(s)	Dates and times (All times are Central, and all webinars last one hour.)		
Summer Enrollment Overview	ERS	June 21; 10 a.m. June 23; 10 a.m. June 25; 10 a.m. June 28; 1 p.m. June 29; 1 p.m.	July 1; 3 p.m. July 6; 8 a.m. July 7; 1 p.m. July 8; 6 p.m. July 13; 10 a.m.	July 15; 10 a.m. July 21; 1 p.m.
Q&A: HealthSelect of Texas®	Blue Cross and Blue Shield of Texas	June 21; 1 p.m. June 29; 10 a.m.	July 9; 1 p.m. July 12; 3 p.m. July 20; 10 a.m.	
Q&A: Consumer Directed HealthSelectSM	Blue Cross and Blue Shield of Texas Optum Bank	June 22; 3 p.m. June 28; 10 a.m.	July 9; 3 p.m. July 13; 3 p.m.	
HMO Transition (from Scott and White Care Plans, Community First Health Plans)	ERS, Blue Cross and Blue Shield of Texas OptumRx	June 21; 3 p.m.	July 1, 10 a.m. July 6; 1 p.m. July 14; 3 p.m.	July 20; 1 p.m.
Q&A HealthSelectSM Prescription Drug Program	OptumRx	June 23; 3 p.m. June 30; 10 a.m.	July 8; 1 p.m. July 22; 1 p.m.	
Q&A: Dental Plans	Delta Dental	June 22; 1 p.m. June 29; 3 p.m.	July 7; 10 a.m. July 12; 10 a.m.	
Q&A: State of Texas VisionSM	Superior Vision	June 24; 3 p.m. June 30; 3 p.m.	July 8; 10 a.m. July 19; 1 p.m.	
Q&A: TexFlexSM	PayFlex® Systems, Inc.	June 25; 1 p.m. June 28; 3 p.m.	July 6; 10 a.m. July 14; 1 p.m.	July 21; 3 p.m.
Q&A: Term Life and AD&D Insurance	Securian Financial	June 24; 1 p.m. June 30; 1 p.m.	July 7; 3 p.m. July 13; 1 p.m.	
Q&A: Texas Income Protection PlanSM	ReedGroup	June 23; 1 p.m.	July 9; 10 a.m. July 19; 3 p.m.	

WHAT'S NEW?

Starting September 1, 2021, the GBP will no longer offer HMOs

The Scott and White Care Plans (SWCP) and Community First Health Plans (CFHP) HMOs will no longer be offered through the Texas Employees Group Benefits Program (GBP) starting September 1, 2021. Central Texas and San Antonio-area HMO participants who are not enrolled in Medicare will be automatically moved to HealthSelect of Texas®, administered by Blue Cross and Blue Shield of Texas (BCBSTX) and have prescription drug coverage administered by OptumRx. During Summer Enrollment, current HMO participants may choose to enroll in Consumer Directed HealthSelectSM, waive GBP health coverage or choose the Health Insurance Opt-Out Credit if they have other group health insurance that is comparable to GBP health insurance. See page 6 of this guide and the insert in your Summer Enrollment packet for more information.

HealthSelectSM plans benefit changes

Starting July 1, 2021, the HealthSelect of Texas, HealthSelect Out-of-State, and HealthSelect Secondary medical plans' in-network virtual visit mental health copays will be covered at no cost to the participant through MDLive and Doctor on Demand.

The HealthSelect plans will also include the benefit changes below starting September 1, 2021.

- The HealthSelect of Texas and Consumer Directed HealthSelect health plans' total annual in-network out-of-pocket maximums (medical and pharmacy combined) will increase to \$7,000 per person per individual (up from \$6,750) and \$14,000 per family (up from \$13,500) to align with the IRS maximums.
- The Consumer Directed HealthSelect and HealthSelect Secondary medical plans will cover in-network diagnostic hemoglobin A1c testing for individuals diagnosed with diabetes without first requiring the annual medical deductible to be met. Coinsurance will still apply.
- Formulary insulin dispensed at in-network pharmacies will be covered under the HealthSelect of Texas and Consumer Directed HealthSelect Prescription Drug Programs, without first having to pay the annual plan deductible. Copays and coinsurance for formulary insulin will still apply.

Changes to flexible spending account (FSA) carryover limits for 2021

The federal Consolidated Appropriations Act of 2021 has changed rules for flexible spending accounts (FSAs) for 2021. All unused funds from Plan Year 2021 TexFlexSM health care, dependent care and limited-purpose FSAs will be carried over to Plan Year 2022. There is no minimum or maximum carryover amount, and there is no 2021 grace period for dependent care accounts.

ERS will no longer offer the TexFlexSM commuter spending account program (CSA) after August 31, 2021

ERS is discontinuing the TexFlex commuter spending account (CSA) program effective September 1. Current CSA participants can continue to use their WageWorks debit card for eligible parking and/or transits purchases incurred prior to August 31, 2021. WageWorks will continue to administer the CSAs through December 31, 2021. After December 31, ERS will refund to each participant funds that remain in their CSA(s) as of January 1, 2022. (Balances of less than a certain amount may not be refunded.) ERS will provide more information to current CSA participants in the coming months. See the insert in your Summer Enrollment packet and page 14 of this guide for more information.

Plan administrator changes

Starting September 1, 2021, PayFlex® Systems, Inc. will be the new administrator of the TexFlex flexible spending account (FSA) program. See the insert in your Summer Enrollment packet and page 14 for more information.

Why are we making this change?

ERS regularly solicits for new administrator and insurer contracts for the benefit programs we offer. It helps ensure we continue to offer competitive benefits at a reasonable cost. For each contract, we thoroughly evaluate all proposals, followed by careful consideration and a vote by the ERS Board of Trustees. We understand the changes can be inconvenient, but they help us save millions of dollars and maintain reasonable premiums and fees.



HOW TO MAKE BENEFITS CHANGES

Update your elections online—fastest and available 24/7

Go online to make changes to your benefits anytime during your two-week enrollment phase:

1. Go to **www.ers.texas.gov**.
2. Click “My Account Login.”
3. Select “Proceed to Login” if you already have a username and password or “Register now” if you need to create an account.
4. After you log in, confirm that your contact information under “My Personal Information” is correct.
5. Click “Benefits Enrollment.”
6. Click the “edit” box in front of the benefit election you want to change. You will need to do this for each election you want to change.
7. Click Submit to save all your changes from the main Benefits Enrollment page.
8. ERS will email you confirmation of your changes, if you have an email address in your ERS account. If you don’t have an email address in your ERS account, we will send a confirmation to your mailing address.

If you don’t have internet access

Contact the Human Resources office or benefits coordinator at your agency or higher education institution. (HHS Enterprise employees can submit changes through the HHS Enterprise Employee Service Center at (888) 894-4747.)

OR

Call ERS toll-free at (866) 399-6908. Be sure to call during your two-week enrollment phase listed on your Personal Benefits Enrollment Statement.

Remember

If you do not need to change your benefit elections, adjust your annual TexFlex flexible spending account contributions or update your tobacco-use status, you do not have to do anything. Your current coverage and contributions will carry forward to the new plan year.

Retirees returning to work

If you are a return-to-work retiree, you can switch between retiree and active benefits to begin on September 1. Contact your agency’s benefits coordinator or Human Resources office during your Summer Enrollment phase. Health and Human Services Enterprise employees: Contact the HHS Employee Service Center.

COVERAGE FOR DEPENDENTS

Your spouse and other eligible dependents can get health insurance and other coverage for an additional premium. However, you must be enrolled in a plan before you can enroll your dependents. Visit ers.texas.gov/New-Employee/Insurance-Eligibility to learn which dependents are eligible for ERS benefits.

Certifying a dependent child

If you want to enroll dependent children in any insurance coverage, you will be asked to certify their eligibility before you submit your enrollment elections.

You can certify your dependent children in one of two ways:

- Log in to your ERS OnLine account and click the “Benefits Enrollment” link under *My Insurance Information*.
or
- Complete and print the Dependent Child Certification form at www.ers.texas.gov/Active-Employees/Forms. You must complete a separate form for each dependent child to be covered. Turn in the completed form(s) to your benefits coordinator or, if you work for HHS, to the HHS Employee Service Center.

Verifying eligible dependents for health coverage

When you enroll any dependent in health coverage, you must prove they are eligible through the dependent eligibility verification (DEV) process:

1. Enroll your eligible dependents in health coverage and certify their eligibility, as noted above.
2. ERS will send your information to Alight Solutions, ERS’ third-party administrator for dependent verification. Alight Solutions will mail you a letter outlining the steps you must take to verify that your dependent is eligible for coverage.
IMPORTANT: When you get a letter from Alight Solutions, open it right away! Carefully review the information and keep the deadline in mind.
3. Submit the necessary documents according to Alight’s instructions by the due date listed on the letter.

If you don’t submit the necessary documents or if you miss the deadline, your dependents will be ineligible and will lose coverage in all GBP plans. If you have questions about dependent eligibility verification, call Alight Solutions toll-free at (800) 987-6605 (TTY: 711).

Adding dependents previously not verified due to dependent eligibility verification (DEV)

If you have dependents who were not verified before because you missed the DEV deadline or could not provide the needed documents, you can add them during Summer Enrollment. To do so, you must submit documentation to ERS (not Alight) to prove your dependent’s eligibility. If the dependents’ eligibility is approved, coverage will begin September 1, 2021.

You must provide copies of documents proving dependent eligibility (see required documents at ers.texas.gov/Benefits-at-a-Glance/Dependent-eligibility-chart.pdf), plus a note with:

- the name of the dependent(s) you are adding to coverage,
- specific coverage type(s) you are electing to add the dependent(s) to (for example: HealthSelect of Texas, State of Texas Dental ChoiceSM, etc.) and
- the GBP member’s name, last four SSN digits and contact phone number.

Mail, fax or email the documentation to ERS. (Do not mail the originals. Documents will not be returned to you.) ERS must get emailed or faxed documents by July 23, 2021. Mailed copies must be postmarked by July 23.

Mail: Employees Retirement System of Texas
P.O. Box 13207
Attn: Benefit Support Services
Austin, TX 78711-3207

Fax: (512) 867-7438

Email: erscustomer.service@ers.texas.gov

Adding coverage for a dependent previously not verified? Don’t miss this deadline

ERS must get complete and accurate documentation verifying that dependents are eligible for coverage by July 23, 2021 in order for coverage to begin on September 1.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

Starting September 1, 2021, the Scott and White Care Plans (SWCP) and Community First Health Plans (CFHP) HMOs will no longer be offered through the Texas Employees Group Benefits Program (GBP). HMO participants who are not enrolled in Medicare will automatically move to HealthSelect of Texas®, administered by Blue Cross and Blue Shield of Texas (BCBSTX) and have prescription drug coverage administered by OptumRx. During Summer Enrollment, current HMO participants may choose to enroll in Consumer Directed HealthSelectSM, waive GBP health coverage or, if they have other group health insurance that is comparable to GBP health insurance, select the Health Insurance Opt-Out Credit. ERS will mail information about the health plan transition to current HMO participants.

SWCP and CFHP participants should see little difference in medical and prescription drug benefits between the HMOs and HealthSelect of Texas, and in most instances, HealthSelect of Texas benefits are better.

Consumer Directed HealthSelect is a high-deductible health plan with a health savings account (HSA), and is very different from the HMOs. Eligible members who enroll in Consumer Directed HealthSelect will get a contribution from the state into their HSA every month, but could have higher out-of-pocket costs.

Most HMO network providers—more than 90%—participate in the HealthSelect network, and most current participants will not need to change their current providers. Participants will have a much larger network of providers and pharmacies to choose from than they have in the HMOs, and if they need to find a new provider, their new plan can help them find the right one.

To get the most out of their HealthSelect of Texas® benefits, current HMO participants will have to contact BCBSTX to name an in-network primary care provider (PCP). After 60 days, if the participant hasn't named a PCP, out-of-network costs apply to most services—even if they're from an in-network provider—until an in-network PCP is named.

Consumer Directed HealthSelect does not require participants to select a PCP or get referrals to specialists.

Unlike the HMOs, HealthSelect plans cover medical and prescription drug services from out-of-network providers, although HealthSelect participants will pay more if they go out of network.

BCBSTX and the HealthSelectSM Prescription Drug Program will send plan guides and new ID cards to SWCP and CFHP participants before September 1, 2021.

Tobacco-use status

All participants enrolled in Texas Employees Group Benefits Program (GBP) health insurance plans must certify their status as tobacco users or non-users. Please note you only need to update your tobacco-use status if you or your dependent(s)' tobacco-use status has changed. A tobacco user is a person who has used any tobacco products five or more times within the past three consecutive months. Certified tobacco users pay a monthly tobacco user premium.

Tobacco products are all types of tobacco, including but not limited to cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, dip and all e-cigarettes and vaping products. If you or a covered family member uses these products, you are required to report it to ERS.

You can update your tobacco-use status during your Summer Enrollment phase through your ERS OnLine account, your agency or higher education institution's benefits coordinator or by returning the Tobacco Use Certification form to ERS. Failing to do so could result in losing your GBP health insurance coverage. If you are using the form to update your tobacco-use status, complete and print the certification form at www.ers.texas.gov/PDFs/Forms/Tobacco_User_Certification_ERS2933. Please

note the form is not necessary if you choose to update certification through your ERS OnLine account or your benefits coordinator.

Participants who change a certification to tobacco user during Summer Enrollment will have the first premium deducted from their October 1 paycheck (employees) or September 30 annuity check (retirees). For more information on the tobacco-user premium, see the Plan Year 2022 rate sheet (available online at www.ers.texas.gov/SE) or your Personal Benefits Enrollment Statement. Read about the tobacco policy at www.ers.texas.gov/About-ERS/Policies/Tobacco-Policy-and-Certification.

If your or a dependent's tobacco use changes during the plan year, you should update the status in your account as soon as possible. You do not have to wait for Summer Enrollment to change your tobacco-use status.

Tobacco user premium alternative

If you are a tobacco user, you may qualify for an alternative to the tobacco user premium, if it complies with your doctor's recommendations. For more information on this alternative, called "Choose to Quit," view the ERS Tobacco Policy on ERS' website (see above).

YOUR HEALTH INSURANCE OPTIONS

View the health plan comparison chart that came in your Summer Enrollment packet to compare commonly used medical, mental health and prescription drug benefits in the HealthSelect plans.

Read the Master Benefit Plan Document for each plan on the HealthSelect website for more details: <https://healthselect.bcbstx.com/content/medical-benefits/index>.

Each plan's Summary of Benefits and Coverage (SBC) also provides an easy-to-understand overview of coverage. Plan Year 2022 SBCs will be available starting June 23.

Health insurance plan features at a glance	HealthSelect of Texas	Consumer Directed HealthSelect of Texas
Key advantages	<ul style="list-style-type: none">• Lower out-of-pocket costs for in-network care• Copays for certain in-network services, like PCP office visits• Large statewide network (large nationwide network for those who live or work outside Texas)	<ul style="list-style-type: none">• Tax-advantaged health savings account (HSA), with monthly contributions from the state• Large statewide and nationwide networks• Referrals not required
In-network preventive care covered at 100%	Yes	Yes
Prescription drug coverage	Yes	Yes
Key downside(s)	<ul style="list-style-type: none">• Referrals needed for most specialty care• Higher monthly premiums for dependents and part-time employees	<ul style="list-style-type: none">• The plan pays nothing until the deductible is met• Must meet IRS' eligibility guidelines to participate in the HSA
Might be good for people who...	<ul style="list-style-type: none">• Want to keep their out-of-pocket costs low• Don't mind getting referrals for specialty care• Are willing to pay higher dependent or part-time employee premiums	<ul style="list-style-type: none">• Usually have low (or very high) health expenses• Can afford to pay for medical and pharmacy expenses out-of-pocket until the deductible is met• Want the state's tax-free HSA contribution• Don't want to get referrals for specialty care

Health Insurance Opt-Out Credit

If you can certify that you have other health insurance that is equal to or better than coverage offered through ERS, you can sign up for the Health Insurance Opt-Out Credit. You must be eligible for the state contribution toward your health insurance premium to qualify for the Opt-Out Credit.

The credit is up to \$60 for full-time employees and \$30 for part-time employees. You can apply this credit to your dental, vision and/or Voluntary Accidental Death & Dismemberment (AD&D) insurance premiums. If you do not use the entire \$60 or \$30 credit, the unused portion cannot be refunded. When you opt out of your health plan, you are also giving up your prescription drug coverage and Basic Term Life Insurance coverage.

The Health Insurance Opt-Out Credit is not available if:

- your only other insurance is Medicare,
- you have health insurance coverage through ERS as a dependent or
- you get a state contribution for other health insurance coverage.

Waiving health coverage: What you should know

If you waive your health coverage, you also give up your prescription drug coverage and will no longer have the \$5,000 Basic Term Life and \$5,000 AD&D coverage.

If you waive your GBP health insurance and later lose your other health coverage due to a valid qualifying life event (QLE), you may enroll in health insurance offered through ERS if you sign up within 31 days of losing your other health insurance coverage.

HEALTHSELECT OF TEXAS AND CONSUMER DIRECTED HEALTHSELECT

Participants in HealthSelect of Texas or Consumer Directed HealthSelect have access to a network of more than 113,000 medical and mental health providers in Texas. Each plan includes a prescription drug program. ERS sets the plan benefits and pays claims. Blue Cross and Blue Shield of Texas (BCBSTX) manages the provider network, processes claims and provides customer service.

HealthSelect[®] of Texas

HealthSelect of Texas is a point-of-service health insurance plan. With this type of plan, you'll pay less if all of your medical care is handled by in-network providers. While the plan will cover out-of-network care, you will pay more—sometimes a lot more—than you pay for in-network care. (Learn about avoiding surprise medical bills at ers.texas.gov/Avoiding-Unexpected-Health-Costs.)

In this plan, you must designate a primary care provider (PCP) in the HealthSelect network and get referrals to specialists to get the highest level of benefit. If your providers are in the HealthSelect network, you do not have to meet a deductible and the plan begins to pay right away.

HealthSelect of Texas annual medical deductibles

Deductibles are based on calendar year and reset January 1.

Note: This does not include the annual \$50 per-person prescription drug deductible.

	In-network	Out-of-network
Individual	\$0	\$500
Family	\$0	\$1,500 (\$500 per participant)*

**See details about how this deductible is applied in the HealthSelect of Texas Master Benefit Plan Document at <https://healthselect.bcbstx.com/content/publications-andforms/index>.*

Copays and coinsurance

HealthSelect of Texas participants are responsible for copays and/or coinsurance for doctor and hospital visits, procedures like outpatient surgery and other medical services. For example, if you have outpatient surgery at an in-network facility, you will owe a \$100 copay and 20% of the allowable amount.

Why do you need a PCP?

HealthSelect of Texas participants who live and work in Texas must get a referral from their designated primary care provider (PCP) to see specialists and get in-network benefits for specialist services. If you do not get a referral from your PCP, you will pay more for your treatment, even if the specialist is in the HealthSelect network.

Your PCP is a valued partner in your health care. He or she gets to know you, your medical history and your lifestyle. If you have a medical issue, your PCP can make it easier and faster to get the care you need.

You do not need a referral from your PCP for:

- routine and diagnostic eye exams;
- OB-GYN visits;
- mental health services;
- chiropractic visits, occupational therapy, speech therapy and physical therapy;
- virtual visits through Doctor on Demand or MDLIVE for medical or mental health care; or
- urgent care centers and convenience care clinics.

Make the most of your HealthSelect benefits

Your health care coverage is not just about helping you when you're sick. Learn about programs and incentives to keep you well at www.healthselectoftexas.com

A BCBSTX Personal Health Assistant also can answer questions about your plan's benefits and coverage and direct you to useful programs and tools. Call toll-free at (800) 252-8039 (TTY: 711), Monday through Friday from 7 a.m. to 7 p.m. CT, and Saturday from 7 a.m. to 3 p.m. CT.

To learn more about your prescription drug benefits, see page 10 of this guide, visit www.healthselectrx.com or call (855) 828-9834 (TTY 711), 24 hours a day, 7 days a week.

CONSUMER DIRECTED

HealthSelectSM

Consumer Directed HealthSelect is a high-deductible health plan paired with a tax-free health savings account (HSA). The high deductible means you could have higher out-of-pocket costs before

your health plan begins to pay for your non-preventive medical services and prescription drugs. The plan covers in-network preventive services at 100%. It is available to GBP participants who are not enrolled in Medicare.

In this plan, you are responsible for all non-preventive health care costs, including prescription drug costs, until you meet the annual deductible. The deductible is based on the calendar year and resets on January 1.

Consumer Directed HealthSelect annual deductibles

For Plan Year 2022 (includes prescription drugs)

	In-network	Out-of-network
Individual	\$2,100	\$4,200
Family	\$4,200	\$8,400

After you meet the deductible, you pay coinsurance (20% in network, 40% out of network) for medical services and prescriptions. You do not have a copay for any services in this plan.

You don't need to designate a primary care provider (PCP) or get referrals to see specialists in Consumer Directed HealthSelect, and generally you will pay less for care—sometimes much less—if you see a provider who is in the network.

Health savings account

Consumer Directed HealthSelect participants can save money by setting up a health savings account (HSA) to pay eligible health care expenses. When you contribute to an HSA, you also save money on federal taxes by lowering your taxable income. Eligible plan participants also get a monthly contribution from the state.

Use money in your HSA to pay for qualified medical expenses for yourself, your spouse and eligible dependents, even if they aren't covered under your insurance. (Learn more at <https://hsastore.com/learn/taxes/who-can-i-cover-hsa> and www.optumbank.com/all-products/medical-expenses.html.)

You can make pre-tax contributions to your HSA through payroll deductions. The IRS sets the maximum contribution amount each year (see chart). If you are age 55 or older, you can contribute an additional \$1,000 each year. All the money in your HSA carries over from one year to the next, and you keep the funds if you change health plans or leave state employment.

HSA contributions and maximums*

Contribution	Individual Account	Family Account**
Annual maximum contribution Jan. 1 – Dec. 31, 2021	Up to age 54: \$3,600 Age 55 and older: \$4,600	\$7,200
Annual maximum contribution Jan 1, 2022 – Dec. 31, 2022	Up to age 54: \$3,650 Age 55 and older: \$4,650	\$7,300
Annual state contribution Sept. 1, 2020 – Aug. 31, 2021	\$540 (\$45 monthly)	\$1,080 (\$90 monthly)

*HSA contributions and limits may change from year to year, or based on eligibility requirements and the participant's age. Maximums are set by the IRS and include both pre-tax and post-tax contributions to an HSA. Monthly contributions are deposited to accounts by the middle of the month.

**A family account includes the GBP member plus any number of dependents enrolled in Consumer Directed HealthSelect.

Enrolling in Consumer Directed HealthSelect? Open an Optum Bank HSA as soon as possible

When you elect to enroll in Consumer Directed HealthSelect through ERS OnLine, you will see a link to the Optum Bank website (optumbank.com) that allows you to immediately open a health savings account (HSA). If you don't open your HSA through ERS OnLine, Optum Bank will send you information about opening an account after you have enrolled in Consumer Directed HealthSelect. You must have an Optum Bank HSA to get the state's contribution; the state will not make deposits into an HSA at another bank.

Once you've opened your HSA, Optum Bank will send you a debit card to pay for eligible health care expenses. Be aware that you have access only to money that has accumulated in your HSA—not funds that have been pledged to be deposited in the future.

Review IRS guidelines or consult a tax advisor to make sure you are eligible to participate in a HSA. For more information, visit www.ers.texas.gov/Contact-ERS/Additional-Resources/FAQs/Consumer-Directed-HealthSelect-Health-Savings-Account.



PRESCRIPTION DRUG COVERAGE

Your health insurance plan includes coverage for prescription drugs. OptumRx administers the prescription drug program for the HealthSelect plans. Learn more about OptumRx at www.healthselectrx.com.

In HealthSelect plans, your prescription drug ID card is separate from your medical ID card. You may need to present your card when filling a prescription.

Prescription drugs fall into three categories, called tiers. Under the HealthSelect Prescription Drug Program, there are different copays for each tier.

- Tier 1 prescriptions are usually inexpensive medications, such as generic drugs.
- Tier 2 prescriptions are usually lower-cost preferred brand-name drugs.
- Tier 3 prescriptions are non-preferred brand-name drugs with a higher cost.

You can lower your own health care costs, and those of the plan, by using generic drugs whenever possible.

Learn more

See the health plans comparison chart that came in your Summer Enrollment packet to compare prescription drug coverage in the different HealthSelect plans. Learn additional details about your prescription drug coverage on your plan's website or at www.ers.texas.gov/Active-Employees/Health-Benefits/Prescription-Drug-Programs.

Out-of-pocket limits on health expenses

To help protect you from extremely high health costs, all GBP health plans have out-of-pocket maximums for care you get from in-network providers (excluding Medicare plans). This is the maximum amount you or your family will pay in one year for in-network copays, coinsurance and deductibles (as applicable) for covered medical and prescription drug expenses. If you reach this maximum, the plan will pay 100% of covered in-network medical and pharmacy expenses for the rest of the year. (There is no out-of-network out-of-pocket maximum in any of the health plans.)

The out-of-pocket maximums for HealthSelect plans reset every calendar year (January 1). The chart below lists the out-of-pocket maximums for the health plans.

In-network out-of-pocket maximums for GBP health plans (excluding Medicare plans)		
Plan Year 2021	HealthSelect (Jan. 1 - Dec. 31, 2021)	\$6,750 individual
	HMOs (through Aug. 31, 2021)	\$13,500 family*
Plan Year 2022	HealthSelect (Jan. 1 - Dec. 31, 2022)	\$7,000 individual \$14,000 family*

*Family includes the GBP member plus one or more covered family member(s).

VISION INSURANCE



Your health insurance plan covers some vision and eye health services, including an annual eye exam and treatment for diseases of the eye (see chart below).

GBP health plans do not cover the cost of eyeglasses or contact lenses. For this type of coverage, you and your eligible dependents can enroll in State of Texas Vision for an additional monthly premium. (Besides the eye exam, any additional vision offerings through the health plans are value-added benefits. ERS does not guarantee the length of time that a specific value-added product will be offered.)

Administered by Superior Vision Services, State of Texas Vision covers an eye exam, contact lens fitting and other eyewear options. The plan includes an allowance for eyeglass frames or contact lenses, as well as discounts for LASIK. The State of Texas Vision plan provides you with an annual allowance of \$200 to use towards either contact lenses OR frames for eyeglasses, and not both. For example, if you choose to use your \$200 allowance to purchase contact lenses, you will not have a frames allowance for the remainder of the year. For a complete list of plan benefits and a list of providers, visit StateOfTexasVision.com.

Vision coverage comparison chart, in-network services

Listed benefits are available for the plan year period, unless indicated. Benefits differ for out-of-network providers and in the HealthSelect Secondary (Medicare) plan. See your health plan materials for details.

	State of Texas Vision	HealthSelect of Texas	Consumer Directed HealthSelect
Routine eye exam	\$15 copay	\$40 copay	After deductible is met: 20% coinsurance; Before deductible is met: possibly the full cost of the exam
Frames	\$200 retail allowance	Not covered	Not covered
Standard contact lens fitting¹	\$25 copay	Not covered	Not covered
Specialty contact lens fitting¹	\$35 copay	Not covered	Not covered
Single-vision lenses	\$10 copay	Not covered	Not covered
Bifocal lenses	\$15 copay	Not covered	Not covered
Trifocal lenses	\$20 copay	Not covered	Not covered
Progressives	\$70 copay	Not covered	Not covered
Polycarbonate	\$50 copay	Not covered	Not covered
Scratch coat (factory, single sided)	\$10 copay	Not covered	Not covered
Ultraviolet coating	\$10 copay	Not covered	Not covered
Tint	\$10 copay	Not covered	Not covered
Standard anti-reflective coating	\$40 copay	Not covered	Not covered
Contact lenses²	\$200 allowance	Not covered	Not covered

¹A contact lens fitting exam has its own copay and is separate from the eye exam copay. Standard contact lens fitting applies to a current contact lens user who wears disposable, daily wear, or extended wear lenses only. Specialty contact lens fitting applies to new contact wearers and/or a participant who wears toric, gas permeable, or multi-focal lenses.

²Contact lenses are in lieu of eyeglass lenses and frames benefits. The \$200 allowance can be used once every plan year. This allowance can be applied to eyeglass frames OR contact lenses, and not both. All costs and allowances are retail; you are responsible for any charges in excess of the retail allowances. Purchases from non-network providers are reimbursed at the non-network rate of up to \$75 retail for frames or up to \$150 retail for contact lenses.



DENTAL INSURANCE



State of Texas Dental Choice

The State of Texas Dental Choice PlanSM is a preferred provider organization (PPO) dental insurance plan. You can see any dentist you want, but you will pay less if you go to a dentist in one of two Delta Dental networks:

- Delta Dental PPO
- Delta Premier

All Delta Dental PPO and Delta Premier dentists are in-network providers. You get the same coverage in either network, but you may pay less for covered services in the Delta Dental PPO network. Delta Premier dentists can charge higher rates for the same covered services.

Benefits are available in the United States, Canada and Mexico, if you live in the United States.

DeltaCare[®] USA

DeltaCare USA dental health maintenance organization

This is a dental health maintenance organization (DHMO) dental insurance plan.

- Coverage applies only to dentists in the Texas service area. Before you enroll, make sure there is a DeltaCare USA network dentist in your area.
- You must choose a primary care dentist (PCD) from a list of approved providers. You and your enrolled dependents can choose different PCDs.
- Services from participating specialty dentists cost 25% less than the dentists' usual charges when specialty care is coordinated by your PCD.

What is a “smart” ID card?

To keep costs low, active employees who sign up for GBP dental insurance will not get an ID card, and participating Delta dentists shouldn't require them.

If you would like a card, you can download a virtual ID card to your smartphone through the Delta Dental app. You can also download and print your ID information from www.ERSdentalplans.com or call Delta Dental toll-free at (888) 818-7925 (TTY: 711) and they will mail a paper copy to you.

Your covered dependents cannot access the Delta Dental app, and their names aren't listed on the ID card. Providers can verify your dependent's coverage using your dependent's name or your name and the plan ID number.

Dental plans comparison chart

This chart is a summary of benefits in the two dental insurance plans. See plan booklets for actual coverage and limitations. Delta Dental 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	DeltaCare USA DHMO (Services from participating PCDs only)
Dentists	In-network/participating dentist	Out-of-network/non-participating dentist*	You must select a primary care dentist (PCD). NOTE: Not all participating dentists accept new patients. Dentists are not required to stay on the plan for the entire year.
Deductibles	Preventive: Individual-\$0; Family-\$0 Combined Basic/Major: Individual-\$50; Family-\$150 Orthodontic services: no deductible	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.	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. DHMO pays nothing.
Maximum calendar year benefits	\$2,000 per covered individual (includes orthodontic extractions)	\$2,000 per covered individual (includes orthodontic extractions)	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 general dentist listed in the directory with a “0” treatment code: child-\$1,800; adult-\$2,100. If care is coordinated by the PCD, participant pays 75% of specialist’s fee. Plan pays \$0.

*In the State of Texas Dental Choice Plan PPO, deductibles and annual maximums are per calendar year. Non-participating dentists can bill for charges above the amount covered by Delta Dental. Visit a participating dentist to ensure you do not have to pay additional charges above the amount covered by Delta Dental.



FLEXIBLE SPENDING ACCOUNTS

TEXFLEXSM By participating in one or more of the TexFlex flexible spending accounts (FSAs), you can set aside pre-tax dollars from your paycheck to cover eligible out-of-pocket health care and/or dependent care expenses. Your TexFlex contribution is automatically withdrawn from your paycheck and deposited into your account each month.

During your Summer Enrollment phase, you can change the amount you contribute to your FSA. If you do not make a change during Summer Enrollment, the annual amount you contribute to your account(s) next plan year will stay the same as this plan year. Keep in mind, there is no maximum carryover amount for Plan Year 2021. Any unused funds will carry over into Plan Year 2022.

After you enroll in a TexFlex health care or limited-purpose FSA, you will get a debit card in the mail. You can use it to pay for eligible expenses, but you cannot use it to pay for dependent care. There is no cost to you to use the debit card.

Because TexFlex accounts are tax-free, the IRS requires all purchases with TexFlex funds to be validated. PayFlex® Systems, Inc., the TexFlex plan administrator, may ask you to submit proof that you used your TexFlex debit card to pay for eligible expenses. **Be sure to save your receipts or explanation of benefits (EOB).**

Active employees may be eligible to enroll in more than one account at a time. See the following chart for rules that apply to each type of account.

FSA program administrator change

PayFlex® Systems, Inc. will be the TexFlexSM FSA program administrator starting September 1, 2021. WageWorks will continue to manage the program through August 31, 2021. This change does not affect how much you can contribute, eligible expenses or other program rules. Current health care and limited-purpose FSA participants will receive a new PayFlex debit card in August. For more information about the TexFlex program, see the insert in your Summer Enrollment packet or visit the ERS website.

TexFlex CSA program discontinued

ERS is discontinuing the TexFlex commuter spending account (CSA) program, effective September 1. You can still use your WageWorks debit card for eligible parking and/or transit purchases through August 31, 2021. After December 31, 2021, ERS will refund to each participant any funds that remain in their CSA(s) as of January 1, 2022. Balances of less than a certain amount may not be refunded and instead will forfeit to the TexFlex plan to help offset administrative costs. WageWorks will continue to administer the CSAs through December 31, 2021. Parking account participants can file claims for expense incurred prior to August 31, 2021. ERS will provide more information to current CSA participants in the coming months.

Why contribute to an FSA?

Contributions to a flexible spending account are deducted before you pay income taxes. Because FSAs lower your taxable income, you save on taxes.

Leftover TexFlex dollars?

Current FSA participants will have their account balances automatically carried over to Plan Year 2022. There is no minimum or maximum carryover amount for Plan Year 2021. See the following chart for more details.



Flexible spending accounts

Health care, limited-purpose and dependent care

	Health care FSA	Limited-purpose FSA (Consumer Directed HealthSelect participants only)	Dependent care FSA
Eligible expenses See complete list at https://texflex.spendingaccounts.info	<ul style="list-style-type: none"> Copays, coinsurance and other medically necessary charges not covered by insurance Prescription drug deductible and copays 	Vision and dental expenses not covered by insurance	<ul style="list-style-type: none"> Day care, after-school care and summer day camp for dependent children under age 13 Adult day care programs for qualifying individuals
Maximum contribution	\$2,750 per participant, per plan year	\$2,750 per participant, per plan year	\$5,000 per household, per plan year
Funds availability	Full election available Sept. 1	Full election available Sept. 1	Funds available monthly as contributions are made
Debit card (no fee)	Yes	Yes	No
Carryover of funds or grace period	A carryover is allowed from the plan year ending August 31, 2021 to the plan year ending August 31, 2022.	A carryover is allowed from the plan year ending August 31, 2021 to the plan year ending August 31, 2022.	A carryover is allowed from the plan year ending August 31, 2021 to the plan year ending August 31, 2022. (The grace period will not apply this year.)
Runout period	Submit claims incurred between Sept. 1, 2021 and Aug. 31, 2022 by Dec. 31, 2022.	Submit claims incurred between Sept. 1, 2021 and Aug. 31, 2022 by Dec. 31, 2022.	Submit claims incurred between Sept. 1, 2021 and Aug. 31, 2022 by Dec. 31, 2022.



TEXA\$AVER

TEXA\$AVERSM While you can open and make changes to a Texa\$aver account anytime, Summer Enrollment is a great time to sign up or make changes to your elections.

Your State of Texas Retirement annuity and Social Security benefits are only part of a financially secure retirement. With Texa\$aver, you can boost your retirement savings through a tax-advantaged account that offers investment flexibility and lower-than-average fees.

Learn more at [www.ers.texas.gov/Active-Employees/Retirement/Texa\\$aver-401\(k\)-457-Program](http://www.ers.texas.gov/Active-Employees/Retirement/Texa$aver-401(k)-457-Program).

Questions about Texa\$aver?

Texa\$aver counselors are always available to answer questions and help with account changes. Visit the Texa\$aver website at www.texasaver.com to schedule an online meeting, or contact a representative toll-free at (800) 634-5091, Monday – Friday, 7 a.m.– 6 p.m. CT.

OPTIONAL TERM LIFE AND VOLUNTARY AD&D INSURANCE



Your health coverage through ERS includes \$5,000 of Basic Term Life Insurance, with \$5,000 of accidental death & dismemberment (AD&D) coverage at no cost to you. This limited coverage probably will not be enough to cover end-of-life and funeral costs or provide for any family who survive you. If you want your family or other people who depend on your salary to have more financial security if you die, you should consider additional life insurance.

Optional Term Life Insurance

During Summer Enrollment, you can apply for additional life Insurance (see evidence of insurability at right) in increments based on your annual salary, with a matching amount of AD&D insurance. You may choose coverage from one to four times your annual salary, up to \$400,000.

Securian's calculator at web1.lifebenefits.com/sites/lbwem/ers/learn-more/how-much-life-insurance-is-enough can help you decide how much life insurance coverage you might need. Premiums and coverage amounts are based on the salary reported to ERS for September 1, 2021.

Dependent Term Life Insurance

For an additional monthly premium, you can apply through EOI to enroll your eligible dependents in dependent term life and AD&D insurance.

If your dependents are approved (see evidence of insurability at right), the benefit includes \$5,000 term life with \$5,000 AD&D for each covered family member. The benefit will be paid to you upon the death of a covered dependent or in the event of certain accidental injuries. Your monthly premium covers all your eligible dependents, but you must list each dependent on your policy.

Voluntary AD&D Insurance

Voluntary AD&D Insurance can provide additional financial protection for you and your family in the event of certain accidental injuries or accidental death. You can choose insurance from \$10,000 up to \$200,000 in increments of \$5,000.

You can sign up for coverage for yourself only, or for yourself and your eligible dependents. EOI is not required for AD&D coverage.

- If you die as the direct result of an accidental bodily injury, your beneficiaries receive the full coverage amount.
- Enrolled family members are covered at partial benefit levels.
- If you have an accident and suffer any of the covered injuries, such as loss of a hand, a foot or sight of one eye, you will receive a benefit up to the full amount of coverage.
- If an insured family member loses a hand, a foot or sight of one or both eyes in an accident, they will receive a percentage of the benefits if you have coverage for that family member.

Evidence of insurability

When you request to enroll in additional life, dependent life and/or disability insurance after your first 31 days of employment, you must provide evidence of insurability (EOI). Evidence of insurability is an application step in which you provide information about your health or that of your dependents.

How to submit your EOI

Initiate the EOI process online after you request to enroll in life and/or disability insurance. You can choose whether you want the EOI underwriter to communicate with you by email or mail. Then:

- The EOI underwriter will provide instructions for submitting your EOI application.
- You must answer all questions on the EOI application truthfully and completely. Missing information can delay the process.
- If needed, the EOI underwriter will request additional information to make a decision on your application.

For questions about the EOI process for life insurance, contact Securian toll-free at (877) 494-1716, Monday – Friday, 8 a.m. – 5 p.m.

For questions about EOI for disability insurance, contact TIPP toll-free at (855) 604-6230, Monday – Friday 7 a.m. – 7 p.m. CT.

Coverage start dates

If you initiate EOI during Summer Enrollment and are approved, your coverage will begin on:

- September 1, 2021, if the EOI approval is dated before September 1 or
- the first day of month following EOI approval if the approval is dated on or after September 1.

Note: You or your dependents may be denied coverage based on information in your EOI application.



DISABILITY INSURANCE



The Texas Income Protection PlanSM (TIPP) provides money to help you pay your bills if an accident or health-related condition makes it impossible for you to work. Reed Group Management, LLC is the administrator for TIPP disability insurance; evidence of insurability (EOI) is underwritten by Guardian Life Insurance.

- Short-term disability insurance provides a maximum benefit of 66% of your monthly salary (up to \$10,000) or \$6,600 monthly, whichever is less. For example, if your monthly salary is \$4,000, the highest amount you'll get for short-term disability is \$2,640 per month. Benefits are paid up to a total of 150 days after you complete the waiting period.
- Long-term disability insurance provides a maximum benefit of 60% of your monthly salary, (with a cap of \$6,000 per month for those making more than \$10,000 monthly). For example, if your salary is \$3,500 per month, your monthly long-term disability payment would be \$2,100. Benefits are paid until you return to work, reach full Social Security retirement age or are no longer considered disabled under the plan. If you become disabled at 69 or older, benefits are payable for up to 12 months. (Note: For some mental diseases and disorders, the maximum benefit period for disability is two years.)

If you are eligible for Social Security Disability Insurance, Workers' Compensation payments, ERS disability retirement benefits, Teacher Retirement System of Texas (TRS) disability retirement benefits and/or other disability payments, your short-term and long-term disability payments may be reduced.

Take note

- Pre-existing conditions are subject to certain exclusions.
- You must use all of your sick leave (including extended sick leave, sick leave pool and donated sick leave) or complete a waiting period (30 days for short-term, 180 days for long-term whichever option is longest), before disability benefits will be paid.
- Please review the plan documents before applying for TIPP disability insurance.
- TIPP coverage is not available to family members.

	Short-term disability coverage	Long-term disability coverage
Monthly benefits	66% of your monthly salary, up to \$10,000	60% of your monthly salary, up to \$10,000
When do benefits start?	After a waiting period of 30 consecutive days or after you've used all your sick leave (whichever is longer); sick leave can be used during the 30-day waiting period	After a waiting period of 180 consecutive days or after you've used all your sick leave (whichever is longer); sick leave can be used during the 180-day waiting period
How long are benefits paid?	Up to 150 days after the completion of your waiting period	Until you are able to return to work or until you reach your Maximum Benefits Period (based on the age you become disabled) or based on the condition causing your disability

Note: TIPP benefits are reduced if you get other disability payments. The minimum benefit is 10% of your monthly salary.

CONTACTS

Health

Plan	Administrator	Phone number	Website
HealthSelect of Texas® HealthSelectSM Out-of-State Consumer Directed HealthSelectSM	Blue Cross and Blue Shield of Texas Group number – 238000	Toll-free: (800) 252-8039 (TTY: 711) Nurseline: (800) 581-0368	www.healthselectoftexas.com
HealthSelectSM Prescription Drug Program Consumer Directed HealthSelect Prescription Drug Program	OptumRx	Toll-free: (855) 828-9834 (TTY: 711)	www.HealthSelectRx.com
Consumer Directed HealthSelect health savings account (HSA)	Optum Bank	Toll-free: (800) 791-9361 (TTY: 711)	www.optumbank.com

Dental

State of Texas Dental Choice PlanSM	Delta Dental Group Number – 20010	Toll-free: (888) 818-7925 (TTY: 711)	www.ERSdentalplans.com
DeltaCare® USA DHMO	Delta Dental Group Number – 79140		

Vision

State of Texas Vision	Superior Vision Services, Inc. Group number – 35040	Toll-free: (877) 396-4128 (TTY: 711)	www.StateofTexasVision.com
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Life and Accidental Death & Dismemberment Insurance

Basic Term Life Insurance Optional Term Life Insurance Dependent Term Life Insurance Voluntary AD&D Insurance	Securian Financial	Toll-free: (877) 494-1716 (TTY: 711)	www.lifebenefits.com/plandesign/ers
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Short-term and long-term disability insurance

Texas Income Protection PlanSM (TIPP)	Reed Group Management, LLC Evidence of Insurability underwritten by Guardian Life Insurance	Toll-free: (855) 604-6230 (TTY: 711)	www.texasincomeprotectionplan.com
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Other programs

TexFlexSM flexible spending account (FSA) program	PayFlex® Security, Inc.	Toll-free: (866) 353-9839 (TTY: 711)	www.texflexers.com
TexFlex commuter spending account (CSA) program	WageWorks, LLC	Toll-free: (844) 884-2364 (TTY: 711)	www.texflexers.com
Texa\$averSM 401(k) / 457 Program	Empower Retirement	Toll-free: (800) 634-5091 (TTY: (800) 766-4952)	www.texasaver.com
Discount Purchase Program	Beneplace	Toll-free: (800) 683-2886 (TTY: 711) Local: (512) 346-3300	www.Beneplace.com/DiscountProgramERS

The Employees Retirement System of Texas (ERS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ERS provides free language aids and services, such as: written information in other formats (large print, audio, accessible electronic formats, and other formats), qualified interpreters, and written information in other languages.

If you need these services, call: 1-877-275-4377, TDD: 711.

If you believe that ERS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail, fax or email:

Mail: Section 1557 Coordinator Employees Retirement System of Texas
P.O. Box 13207, Austin, Texas 78711. Fax: 512-867-3480.

Email: 1557coordinator@ers.texas.gov

For more information visit: <http://www.ers.texas.gov>

You can also file a civil rights complaint with the U.S. Department of Health and Human Services online, by mail or by phone at:

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>.

Mail: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201.

Phone: 1-800-368-1019, 800-537-7697 (TDD).

ATTENTION: Language assistance services, free of charge, are available to you.	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.	સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે.
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ.

1-877-275-4377