2020 Summer Enrollment Active Employee Guide

ERS® Employees Retirement System of Texas

Inside:

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 benefits changes unless you have a qualifying life event during the plan year (see **ers.texas.gov/Active-Employees/Life-Changes-for-active-employees**).

There are no major changes in what your health plan covers for Plan Year 2021. Still, 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 the year ahead. View more details and premium rate sheets at **https://ers.texas.gov/SE**.

When do you need to act?

Your agency or higher education institution is assigned a specific Summer Enrollment phase. You should make any needed changes to your benefits during this two-week period.

Find the dates of your phase in the top left corner of your Personal Benefits Enrollment Statement, or go to **https://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.

All 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.

SUMMER ENROLLMENT WEBINARS

To ensure the health and safety of state employees and retirees during the COVID-19 pandemic, ERS and Texas Employees Group Benefits Program (GBP) plan administrators are hosting several hour-long Summer Enrollment webinars instead of our traditional 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 address general questions; if you have a specific question about your account or a 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 (**https://ers.texas.gov/Event-Calendars**) shortly before the event for any updates. Other webinars may be added. Visit the Summer Enrollment webpage at **https://ers.texas.gov/SE** to check for schedule updates and to access webinar recordings.

ERS Summer Enrollment webinars

Register at **https://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 22; 10 a.m. June 24; 10 a.m. June 26; 10 a.m. June 30; 1 p.m.	July 1; 1 p.m. July 2; 1 p.m. July 8; 3 p.m. July 10; 3 p.m.	July 14; 10 a.m. July 16; 10 a.m. July 20; 1 p.m. July 22; 1 p.m.
Q&A: HealthSelect of Texas®	Blue Cross and Blue Shield of Texas	June 22; 3 p.m. July 2; 3 p.m.	July 10; 1 p.m. July 13; 3 p.m.	July 21; 10 a.m.
Q&A: Consumer Directed HealthSelect℠	Blue Cross and Blue Shield of Texas Optum Bank	June 23; 3 p.m. July 3; 10 a.m.	July 6; 1 p.m. July 14; 3 p.m.	July 20; 10 a.m.
Q&A: HealthSelect℠ Prescription Drug Program	OptumRx	June 24; 3 p.m.	July 1; 10 a.m.	
Q&A: Scott and White Health Plan (HMO)	Scott and White Health Plan	June 26; 3 p.m.	July 7; 1 p.m.	July 15; 3 p.m.
Q&A: Community First Health Plans (HMO)	Community First Health Plans	June 25; 3 p.m.	July 9; 1 p.m.	July 17; 3 p.m.
Q&A: Dental Plans	Delta Dental	June 22; 1 p.m. June 30; 3 p.m.	July 8; 10 a.m. July 16; 1 p.m.	July 21; 3 p.m.
Q&A: State of Texas Vision℠	Superior Vision	June 23; 1 p.m. July 1; 3 p.m.	July 9; 10 a.m. July 17; 1 p.m.	July 20; 3 p.m.
Q&A: TexFlex℠	WageWorks	June 26; 1 p.m. June 29; 3 p.m.	July 7; 10 a.m. July 14; 1 p.m.	July 22; 3 p.m.
Q&A: Term Life and AD&D Insurance	Securian Financial	June 25; 1 p.m. July 3; 3 p.m.	July 6; 10 a.m. July 15; 1 p.m.	
Q&A: Disability Insurance	ReedGroup	June 24; 1 p.m. July 2; 3 p.m.	July 10; 10 a.m. July 13; 1 p.m.	

In August, ERS will offer webinars on the change in the HealthSelect℠ mental health benefits administrator and the new HealthSelectShoppERS℠ program (available only to active employees). View the Events webpage (**https://ers.texas.gov/Event-Calendars**) for details.

What's new?

Tobacco-user status will include e-cigarettes and vaping

Starting September 1, 2020, GBP health plan participants who use tobacco, electronic cigarettes or vaping products will be considered tobacco users and must certify as such. If you or your covered dependents use these products and are currently certified as tobacco non-users, you will need to update the tobacco-use status to tobacco user. You can update your and/or your dependents' tobacco-use status during your assigned two-week Summer Enrollment phase.

Contribution limits increased for HSAs and some FSAs

- The IRS has increased contribution limits for health savings accounts (HSAs) in Calendar Year 2021 to $3,600 for an individual and $7,200 for a family. (Only members enrolled in Consumer Directed HealthSelect may contribute to an HSA. See page 7.)
- The IRS has increased contribution limits for health care and limited-purpose flexible spending accounts (FSAs) from $2,700 to $2,750. You may increase your contribution to these TexFlex accounts during Summer Enrollment. (See page 12.)

HealthSelectShoppERS: A new way to save

Eligible HealthSelect participants earn incentives when they shop for and choose a lower-cost, in-network option for certain elective medical services and procedures. Read the HealthSelectShoppERS handout included in your Summer Enrollment packet for details.

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" in the upper right corner.
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." Confirm that the last four digits of the Social Security number and date of birth for each of your dependents are correct and begin making your changes.

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 flexible spending account contributions or update your tobacco-use status, **no action is required**. 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 during your Summer Enrollment phase. Contact your agency's benefits coordinator or Human Resources office to do so. **Health and Human Services Enterprise employees**: Contact the HHS Employee Service Center before July 24.

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 more about benefits eligibility.

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 dependents through your ERS OnLine account or you can complete and print the Dependent Child Certification form at **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 a dependent for health coverage

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

1. Enroll your dependent(s) in health coverage and certify dependent child(ren), as noted above.
2. ERS will process your request.
3. Alight Solutions, ERS' third-party administrator for dependent verification, will mail you a letter outlining the steps you must take to verify that your dependent is eligible for coverage.
4. **IMPORTANT:** When you get a letter from Alight Solutions, open it right away! Carefully review the information and keep the deadline in mind.
5. Submit the necessary documents according to Alight's instructions.

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 DEV

If you have dependents who previously were not verified 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 dependent eligibility is approved, coverage will begin September 1, 2020.

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) (for example: HealthSelect of Texas, State of Texas Dental Choice℠, etc.),
- tobacco-user status of dependents you are adding to health coverage and
- the GBP member's contact phone number.

Mail, fax or email the documentation to ERS. (Do not mail the originals.) ERS must receive emailed or faxed documents by July 24, 2020. Mailed copies must be postmarked by July 24.

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 receive complete and accurate documentation verifying that newly added dependents are eligible for coverage by **July 24, 2020**.

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 GBP health plans.

Read the Master Benefits Plan Document on each plan's website for more details. Each plan's Summary of Benefits and Coverage (SBC) also provides an easy-to-understand overview of coverage. Find SBCs on the ERS website at **https://ers.texas.gov/Active-Employees/Summaries-of-Benefits-and-Coverage**.

Health insurance plan features at a glance

	HealthSelect of Texas	Consumer Directed HealthSelect of Texas	Community First Health Plans, Scott and White Health Plan
Key advantages	• 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)	• Tax-advantaged health savings account (HSA), with monthly contributions from the state • Large statewide and nationwide networks • Referrals not required	• Low out-of-pocket costs for in-network care • Lower monthly premiums
In-network preventive care covered at 100%	Yes	Yes	Yes
Prescription drug coverage	Yes	Yes	Yes
Key downside(s)	• Referrals needed for most specialty care • Higher monthly premiums for dependents and part-time employees	• The plan pays nothing until the deductible is met • Must meet IRS' eligibility guidelines to participate in the HSA	• Limited regional network • Plan pays nothing for out-of-network care (except emergencies)
Might be good for people who…	• 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	• 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	• Want to keep their out-of-pocket costs low • Don't mind getting all non-emergency care from a smaller, regional network • Want to pay lower dependent or part-time employee premiums

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 a monthly 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.

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.

Opting out: What you should know

If you opt out of your health plan, you give up your prescription drug coverage and will no longer have $5,000 Basic Term Life and $5,000 AD&D coverage.

If you subsequently lose your other insurance coverage, it is considered a qualifying life event. As a result, 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 50,000 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) and get referrals to specialists. If your PCP is 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.

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

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

*See details about how this deductible is applied in the HealthSelect of Texas Master Benefit Plan Document at **https://healthselect.bcbstx.com/content/publications-and-forms/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 or work in Texas must get a referral from their designated primary care provider (PCP) to see specialists and receive 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 **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 8 of this guide, visit **www.healthselectrx.com** or call (855) 828-9834 (TTY 711), 24 hours a day, 7 days a week.

CONSUMER DIRECTED HealthSelect℠

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 100% for in-network preventive services. 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 Calendar Years 2020 and 2021 (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 a referral to see a specialist in Consumer Directed HealthSelect, but you will generally 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, 2020	Up to age 54: $3,550 Age 55 and older: $4,550	$7,100
Annual maximum contribution Jan. 1 – Dec. 31, 2021	Up to age 54: $3,600 Age 55 and older: $4,600	$7,200
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 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.

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 **https://ers.texas.gov/Contact-ERS/Additional-Resources/FAQs/Consumer-Directed-HealthSelect-Health-Savings-Account**.

HEALTH MAINTENANCE ORGANIZATIONS (HMOS)

If you live or work in an eligible county, you have the option of enrolling in an HMO. These regional plans have smaller networks than the HealthSelect plans, but they cover the same care and services and generally have lower dependent and part-time premiums.

You must use providers (such as doctors and hospitals) in the HMO network for your services to be covered, unless the health plan has authorized out-of-network treatment. Only emergency care services are covered outside the network without authorization.

HMOs have their own prescription drug coverage. The annual prescription drug deductible is $50 per person per plan year, which resets on September 1.

HMO Plan	Service Area	Counties
Community First Health Plans	San Antonio	Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina and Wilson
Scott and White Health Plan	Central Texas	Austin, Bastrop, Bell, Bosque, Brazos, Burleson, Burnet, Coryell, Falls, Freestone, Grimes, Hamilton, Hill, Lampasas, Lee, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, Travis, Walker, Waller, Washington and Williamson

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, with 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 GBP health plans. Learn additional details about your prescription drug coverage on your plan's website or at **https://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 in-network out-of-pocket maximums. 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 provider 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), while the HMOs reset every plan year (September 1). The chart below lists the out-of-pocket maximums for the health plans.

In-network out-of-pocket maximums (all plans)		
Plan Year 2020	HealthSelect (through Dec. 31, 2020)	$6,750 individual $13,500 family*
	HMOs (through Aug. 31, 2020)	
Plan Year 2021	HealthSelect (Jan. 1 - Dec. 31, 2021)	$6,750 individual $13,500 family
	HMOs (Sept. 1, 2020 – Aug. 31, 2021)	

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

VISION INSURANCE

STATE OF TEXAS VISION

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).

With the exception of the Community First Health Plans HMO, 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. For a complete list of plan benefits and a list of providers, visit **StateOfTexasVision.com**.

Vision coverage comparison chart, in-network services

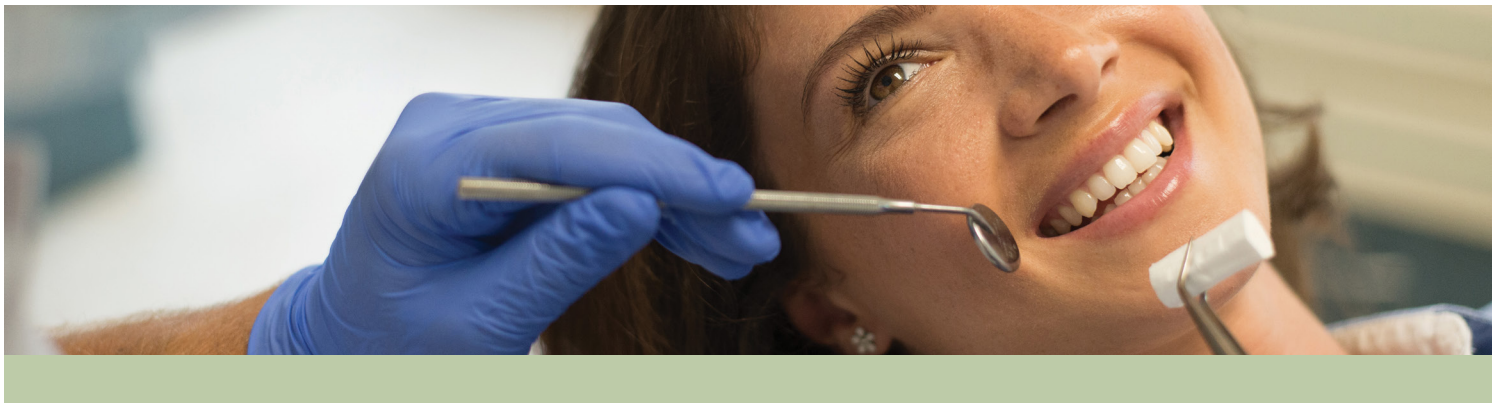
Listed benefits are available for the plan year period, unless indicated. Benefits differ for out-of-network providers and in the HealthSelect Secondary (Medicare) plan. See your health plan materials for details.

	State of Texas Vision	HealthSelect of Texas	Consumer Directed HealthSelect	Community First HMO	Scott and White HMO
Routine eye exam	$15 copay	$40 copay	20% coinsurance after deductible is met	$40 copay at any in-network doctor	$40 copay
Frames	$200 retail allowance	Not covered	Not covered	$125 retail allowance[1]	Not covered
Standard contact lens fitting	$25 copay	Not covered	Not covered	$125 allowance[2]	Not covered
Specialty contact lens fitting	$35 copay	Not covered	Not covered	Not covered	Not covered
Single-vision lenses	$10 copay	Not covered	Not covered	100% covered	Not covered
Bifocal lenses	$15 copay	Not covered	Not covered	100% covered	Not covered
Trifocal lenses	$20 copay	Not covered	Not covered	100% covered	Not covered
Progressives	$70 copay	Not covered	Not covered	Not covered	Not covered
Polycarbonate	$50 copay	Not covered	Not covered	Not covered	Not covered
Scratch coat (factory, single sided)	$10 copay	Not covered	Not covered	Not covered	Not covered
Ultraviolet coating	$10 copay	Not covered	Not covered	Not covered	Not covered
Tint	$10 copay	Not covered	Not covered	Not covered	Not covered
Standard anti-reflective coating	$40 copay	Not covered	Not covered	Not covered	Not covered
Contact lenses[2]	$200 allowance	Not covered	Not covered	$125 allowance	Not covered

[1]Cost savings when using OptiCare vision providers. Frame discounts are not available if the frame manufacturer prohibits the discount.

[2]Contact lenses are in lieu of eyeglass lenses and frames benefits.

All costs and allowances are retail; you are responsible for any charges in excess of the retail allowances.



DENTAL INSURANCE

State of Texas Dental Choice

State of Texas Dental Choice 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 coverage.

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

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 DHMO 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.

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.

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.

Covered dependents cannot access the app, and their names aren't listed on the card. A dependent can verify coverage with a provider by giving either their name or the GBP member's name and plan ID number.

Check the Discount Purchase Program for dental discounts

The Discount Purchase Program℠, administered by Beneplace, offers dental discount programs and discounted dental services. View them at **https://www.beneplace.com/discountprogramers/**. (To access discounts, you will need to register using your email address.)

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. 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. Orthodontic services performed by specialist: 75% of the usual fee. DHMO pays nothing.

*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.

TEXFLEX

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

Summer Enrollment is the only time you can change the amount you contribute to your TexFlex account (except for a commuter spending account), unless you have a qualifying life event during the plan year. 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.

After you enroll in a TexFlex commuter, 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. Current participants will not get a new card this year unless their current card is expiring.

Because TexFlex accounts are tax-free, the IRS requires all purchases with TexFlex funds to be validated. WageWorks, the TexFlex plan administrator, may ask you to submit proof that you used your TexFlex funds to pay for eligible expenses. SAVE YOUR RECEIPTS.

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.

Note: You can enroll in or make changes to the TexFlex commuter spending account for transit and/or parking at any time; you don't have to wait for Summer Enrollment. If you enroll in the TexFlex health care or limited-purpose FSA and a TexFlex CSA, you will not get separate debit cards: You can use the same debit card for the parking or transit CSA and your health care or limited-purpose FSA.

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?

You can carry over up to $500 in a health care or limited-purpose FSA from one plan year to the next. You will lose any funds over $500 in either of those accounts if you do not spend them by the end of the plan year. (Starting September 2021, the total amount you can carry over will increase. See chart.)

You cannot carry over any funds in a dependent care FSA, but you have 2½ months after the plan year ends to spend leftover money in that account. See the 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**	• Copays, coinsurance and other medically necessary charges not covered by insurance • Prescription drug deductible and copays	Vision and dental expenses not covered by insurance	• 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 of up to $500 is allowed from the plan year ending August 31, 2020 and up to $550 from the plan year ending August 31, 2021.	A carryover of up to $500 is allowed from the plan year ending August 31, 2020 and up to $550 from the plan year ending August 31, 2021.	Grace period (extra time to incur expenses under FY20 account) from Sept. 1, 2020 to Nov. 15, 2020
Runout period	Submit claims incurred between Sept. 1, 2020 and Aug. 31, 2021 by Dec. 31, 2021	Submit claims incurred between Sept. 1, 2020 and Aug. 31, 2021 by Dec. 31, 2021	Submit claims incurred between Sept. 1, 2020 and Nov. 15, 2021 by Dec. 31, 2021

Commuter

	Transit	Parking
Eligible expenses See complete list at **https://texflex.spendingaccounts.info**	Eligible mass transit or vanpool expenses associated with travel to and from work, including bus, train or subway	Eligible parking expenses either near your place or employment or at a location from which you commute to work via transit or vanpool
Maximum monthly contribution	$270 per month	$270 per month
Funds availability	As contributions are made	As contributions are made
Debit card (no fee)	Yes	Yes
Carryover of funds	Funds can be used as long as you are actively employed. Every month, any balance greater than $3 rolls over to the next month and is subject to the $3 monthly administrative fee. If you are enrolled in both parking and transit accounts, the $3 administrative fee is only deducted from one account. Any amount less than $3 is forfeited.	
Reimbursements	Participants must use the TexFlex debit card to pay for eligible transit expenses—the IRS doesn't accept manually submitted claims for reimbursement of transit-related expenses.	Participants have 180 days from the date they incurred a parking expense to submit the claim to WageWorks.

TEXA$AVER℠ 401(K) / 457 PROGRAM

TEXA$AVER℠ 401(k) / 457 Program

While you can open 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**.

Questions about Texa$aver?

Texa$aver counselors are always available to answer questions and help with account changes. Visit the Texa$aver website at **https://texasaver.empower-retirement.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.

Vaping and e-cigarettes added to definition of tobacco use

All participants enrolled in Texas Employees Group Benefits Program (GBP) health insurance plans must certify their status as tobacco users or non-users. 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.

In March, the ERS Board of Trustees voted to update the definition of tobacco products in ERS' tobacco policy to include electronic cigarettes and vaping products. If you or a covered family member uses these products, you are required to report it to ERS by August 31, 2020.

You can update your tobacco-use status during your Summer Enrollment phase through your ERS OnLine account, by phone or by returning the Tobacco Use Certification form to ERS. Failing to do so could result in losing your GBP health insurance coverage. Complete and print the certification form at **https://www.ers.texas.gov/PDFs/Forms/Tobacco_User_Certification_ERS2933**.

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 2021 rate sheet (available online at **https://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 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).

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 on September 1.

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, you 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. CT.

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 receive EOI approval, coverage begins:

- on September 1, 2020, if the EOI approval is dated before September 1.
- 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

TIPP
Texas Income Protection Plan For State Employees ERS

The Texas Income Protection Plan℠ (TIPP) provides money to help you pay your bills if an accident or health-related condition makes it impossible for you to work.

TIPP disability insurance is administered by ReedGroup; the 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 up to five months (a maximum of 150 days). For example, if your monthly salary is $4,000, the highest amount you'll get for short-term disability is $2,640 per month.
- 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.

NOTICE OF CREDITABLE COVERAGE PLAN YEAR 2021

This notice applies to you if you are both:

- entitled to Medicare Part A and/or enrolled in Medicare Part B and
- enrolled in Texas Employees Group Benefits Program health insurance.

Important notice from the Employees Retirement System of Texas (ERS) about your Texas Employees Group Benefits Program (GBP) prescription drug coverage and Medicare Prescription Drug Coverage (sometimes called Part D).

Please read this notice carefully and keep it where you can find it. No action is required of you at this time.

Federal law requires ERS to send this notice to people who may be eligible for Medicare Prescription Drug Coverage and are enrolled in health insurance that is part of the GBP provided by the State of Texas. You have GBP prescription drug coverage through your GBP enrollment with HealthSelect℠ of Texas, administered by UnitedHealthcare, or one of the other health plans offered by the state.

This notice provides:

- important information about your current prescription drug coverage,
- answers that will assist you in deciding whether you should purchase Medicare Prescription Drug Coverage,
- contact numbers for more information and
- a document that you can use later to avoid a penalty for late enrollment in Medicare Prescription Drug Coverage.

Q. What is Medicare Prescription Drug Coverage (sometimes called Part D)?

A. Medicare Prescription Drug Coverage is a prescription program that is available to people who qualify for Medicare Part A or Medicare Part B. Medicare Prescription Drug Coverage started on January 1, 2006.

Q. What is creditable coverage and does GBP coverage meet this definition?

A. The prescription drug coverage offered by the GBP has been examined by ERS' consulting actuaries and is, on average for all plan participants, expected to pay out as much as standard Medicare Prescription Drug Coverage pays. The GBP is therefore considered to be creditable coverage.

Q. Why is creditable coverage important to Medicare-eligible participants in the GBP?

A. Because you have creditable coverage under the GBP, the Social Security Administration (SSA) has said that you will not have to pay a penalty if you join a private Medicare prescription drug plan later. Each year, there is an enrollment period that allows people with Medicare to enroll in private Medicare Prescription Drug Coverage. Although you will have a chance to enroll every year, normally you would have to pay a penalty if you enrolled after your initial eligibility date. However, because you have creditable coverage under the GBP, you can choose to join a private Medicare prescription drug plan later without a penalty.

Q. Should I enroll in private Medicare Prescription Drug Coverage?

A. Most Medicare-eligible participants in the GBP should NOT enroll in private Medicare Prescription Drug Coverage because, for most people, the GBP prescription drug coverage will provide better benefits at a lower cost. If you qualify for financial assistance, you could benefit from private Medicare Prescription Drug Coverage and you would get savings on premiums, copays and coinsurance.

Q. How do I know if I qualify for financial assistance with private Medicare Prescription Drug Coverage?

A. Financial assistance is available to Medicare beneficiaries with incomes up to 150% of the Federal Poverty Level (FPL) and limited resources. The FPL is set each year. ERS does not make this determination or set the guidelines. To determine if you qualify for financial assistance with private Medicare Prescription Drug Coverage, you should contact the SSA toll-free at (800) 772-1213. TTY users should call toll-free at (800) 325-0778. Or visit SSA online at **www.socialsecurity.gov**.

Q. Is private Medicare Prescription Drug Coverage free?

A. No. If you enroll in private Medicare Prescription Drug Coverage, you will pay a monthly premium. The amount will likely increase each year. You will also have to pay the private Medicare Prescription Drug Coverage deductibles and copays. Currently, the deductible may be as high as $435, and will increase to $445 in 2021.

Q. How does private Medicare Prescription Drug Coverage work?

A. Medicare Prescription Drug Coverage is offered through private prescription drug plans that have been approved by Medicare. All private Medicare prescription drug plans offer a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium. If you enroll in a private Medicare prescription drug plan, you will receive a prescription drug card that you will present to your pharmacy to cover a portion of your prescription drug costs.

Q. Will private Medicare Prescription Drug Coverage have any effect on my medical plan under the GBP?

A. Yes, if the private Medicare Prescription Drug plan also includes Medicare Advantage medical coverage. Medicare rules do not allow you to be enrolled in a GBP Medicare Advantage plan (HealthSelect℠ Medicare Advantage, or KelseyCare Advantage MA HMO) and a private Medicare Prescription Drug plan that includes Medicare Advantage medical coverage at the same time. If you enroll in private Medicare Prescription Drug Coverage and it has a Medicare Advantage medical plan included, your medical coverage with the GBP Medicare Advantage plan will be terminated and you will be automatically enrolled in your previous non-Medicare Advantage plan under the GBP. If you are enrolled in a non-Medicare GBP medical plan, there is no change to your medical coverage.

If you enroll in ERS' HealthSelect Medicare Advantage or KelseyCare Advantage MA HMO, and do not decline ERS' HealthSelect Medicare RX prescription drug coverage, your private Medicare Prescription Drug Coverage will be terminated.

Q. Will private Medicare Prescription Drug Coverage have any effect on HealthSelect Medicare Rx?

A. Yes. Medicare rules do not allow you to be in two different Medicare prescription plans at the same time. If you enroll in a private Medicare prescription plan you will no longer be eligible for the HealthSelect℠ Medicare Rx plan and will lose all prescription coverage through ERS.

Q. Most GBP participants were encouraged not to enroll in private Medicare Prescription Drug Coverage last year. What about future years?

A. You do not need to sign up for private Medicare Prescription Drug Coverage for the coming plan year. However, you should know that if you drop or lose your coverage under the GBP and do not enroll in private Medicare Prescription Drug Coverage within 63 days after your current GBP coverage ends, you may be required to pay more to enroll in private Medicare Prescription Drug Coverage later.

Q. Where can I get more information?

A. More detailed information about private Medicare plans that offer prescription drug coverage is available in the *Medicare & You* handbook. You may have received a copy of the handbook in the mail from Medicare. The handbook is also available at the website below. You may also be contacted directly by approved, private Medicare prescription drug plans. To get more information about private Medicare prescription drug plans:

- Visit **www.medicare.gov** for personalized help.
- Call your State Health Insurance Assistance Program. (See your copy of the *Medicare & You* handbook for their telephone number.)
- Call toll-free at (800) MEDICARE (800) 633-4227. TTY users should call (877) 486-2048.

NOTE: *You may receive this notice at other times in the future, such as before the next period you can enroll in Medicare Prescription Drug Coverage or if this coverage changes. You may also request a copy of this notice by calling ERS toll-free at (877) 275-4377.*

Keep this notice. If you enroll in one of the Medicare-approved prescription drug plans at a later date, you may need to submit a copy of this notice when you join to show that you are not required to pay a higher premium amount.

CONTACTS

Health

Plan	Administrator	Phone number	Website
HealthSelect of Texas **HealthSelect℠ Out-of-State** **Consumer Directed HealthSelect**	Blue Cross and Blue Shield of Texas Group number – 238000	Toll-free: (800) 252-8039 (TTY: 711) Nurseline: (800) 581-0368	**www.healthselectoftexas.com**
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**
Community First Health Plans	*An affiliate of University of Health System* Group number – 0010180000	Toll-free: (877) 698-7032 (TTY: 711 or (210) 358-6080) Local: (210) 358-6262 NurseLink: (210) 358-6262	**members.cfhp.com**
Scott and White Health Plan	Group number – 012700	Toll-free: (800) 321-7947 (TTY: (800) 735-2989) VitalCare Nurse Advice: (877) 505-7947	**https://ers.swhp.org**

Dental

State of Texas Dental Choice PPO	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**

Life and Accidental Death & Dismemberment 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**

Short-term and long-term disability insurance

Texas Income Protection Plan (TIPP)	ReedGroup Evidence of insurability underwritten by Guardian Life	Toll-free: (855) 604-6230 (TTY: 711)	**www.texasincomeprotectionplan.com**

Other programs

TexFlex	WageWorks, LLC	Toll-free: (844) 884-2364 (TTY: 711)	**www.texflexers.com**
Texa$aver 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, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ.