2020 Summer Enrollment COBRA/COBRA Disability Guide

ERS® Employees Retirement System of Texas

Inside:

Benefits to protect your health and future

The State of Texas offers a valuable benefits package to support your health and well-being.

COBRA is the federal law that allows certain former employees, retirees, spouses, former spouses and dependent children to temporarily continue insurance coverage at group rates. For information about COBRA eligibility, see **https://ers.texas.gov/Former-Employees/COBRA-continuation-coverage**.

Summer Enrollment is a chance to take another look at your benefits and make changes to the coverage available to you through COBRA.

There are no major changes in what your health plan covers for Plan Year 2021. Still, you should make the most of this opportunity to refresh your knowledge about your coverage options. View more details and premium rate sheets at **https://www.ers.texas.gov/SE**.

When do you need to act?

You are assigned a specific Summer Enrollment phase. You should make benefits changes during this two-week period. The assigned two-week enrollment phase for individuals with coverage through COBRA is **July 13 – July 24**.

No changes? No action needed

If you wish to keep your same coverage, you do not need to do anything. Your current benefits will stay the same.

Benefit elections for the new plan year are effective September 1.

All Texas Employees Group Benefits Program (GBP) benefits could change without notice. The Texas Legislature decides the level of funding for such benefits and has no continuing obligation to provide those benefits beyond each fiscal year.

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 anywhere you have internet access. 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.	

What's new?

Tobacco-user status will include e-cigarettes and vaping

Starting September 1, 2020, GBP health plan participants who use electronic cigarettes or vaping products will be considered tobacco users and must certify as such. If you or a covered dependent uses these products and are currently certified as a tobacco non-user, you will need to change the status to tobacco user during your assigned Summer Enrollment phase. (Read more on page 12.)

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

Complete and send ERS the form included in this guide OR call ERS toll-free at (866) 399-6908. Be sure to call during your two-week enrollment phase, **July 13 – July 24**.

Remember

If you do not need to change your benefit elections or change your tobacco use status, **no action is required**. Your current coverage will carry forward to the new plan year.

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 **https://ers.texas.gov/PDFs/Dependent-eligibility-chart.pdf** 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.

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 **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 member's contact phone number.

Mail, fax or email the documentation to ERS. (Do not send 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 for a comparison of commonly used medical, mental health and prescription drug benefits in GBP health plans.

Read more about what each plan covers in the Master Benefits Plan Document on the plan's website. Also, each plan's Summary of Benefits and Coverage (SBC) provides a quick, easy-to-understand overview of coverage. SBCs are on the ERS website at **https://ers.texas.gov/Summaries-of-Benefits-and-Coverage**.

Health insurance plan features at a glance

	Point-of-service plan	High-deductible plan with HSA	HMOs
	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

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. While 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. OptumRx administers the prescription drug program.

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**.)

With this type of 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 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

2020-2021 Deductible (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 tax-free health savings account (HSA) for health care expenses. When you contribute to an HSA, you save money on federal taxes by lowering your taxable income .

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**.)

All the money in your HSA carries over from one year to the next, and you keep the funds if you change health plans.

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

*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.

Why set up an HSA?

Optum Bank administers the HSA for ERS; however, because the State of Texas does not contribute to your HSA when you're no longer a state employee, you can open an HSA at any bank that offers them (including Optum Bank). If you already have an Optum Bank HSA, you can continue to use that account.

According to IRS regulations, you must be enrolled in a high-deductible health plan (like Consumer Directed HealthSelect) to contribute to an HSA. Before enrolling in Consumer Directed HealthSelect, you should review IRS guidelines or consult a tax advisor to make sure you are eligible to participate in an HSA.

Learn more at **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 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 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/Former-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
	HMOs (through Aug. 31, 2020)	$13,500 family*
Plan Year 2021	HealthSelect (Jan. 1 - Dec. 31, 2021)	$6,750 individual
	HMOs (Sept. 1, 2020 – Aug. 31, 2021)	$13,500 family

**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).

Except for 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

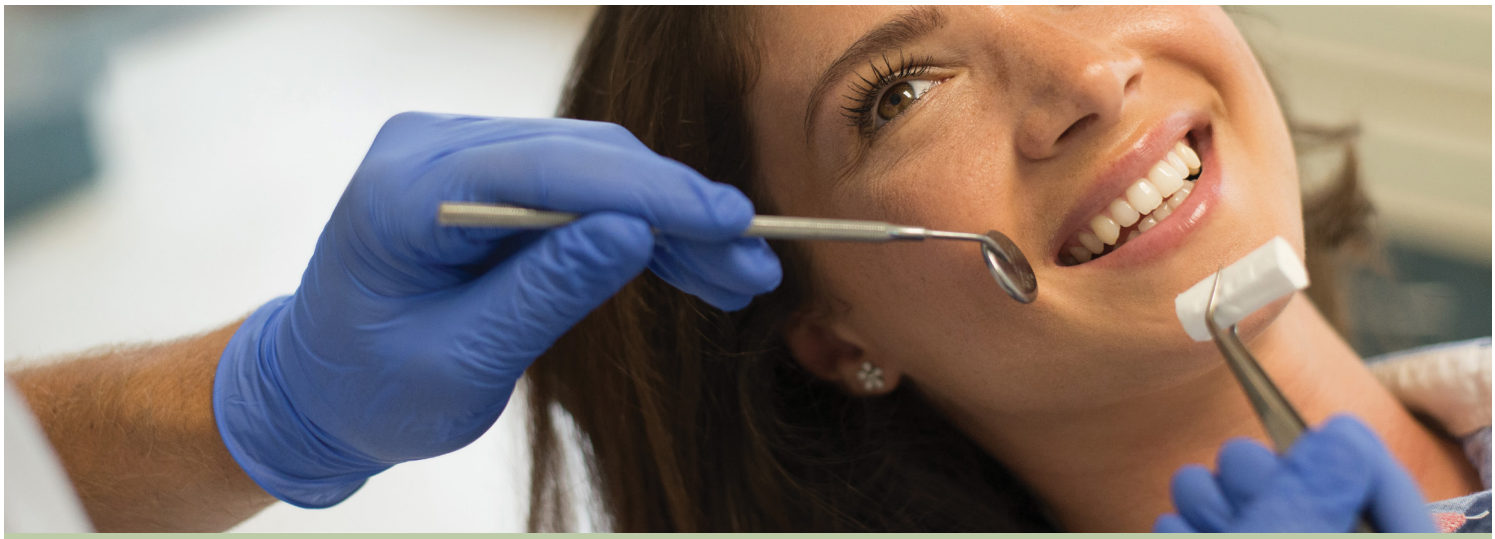
Listed benefits are available for the plan year period, unless indicated. Benefits differ for out-of-network providers and in the HealthSelect Secondary (Medicare) plan. See your health plan materials for details.

	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	$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?

While participating Delta dentists shouldn't require a plan ID card, you can download a virtual ID card to your smartphone anytime 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 member's name and 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. 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.

CONTACTS

Health

Plan	Administrator	Phone number	Website
HealthSelect of Texas	Blue Cross and Blue Shield of Texas Group number – 238000	Toll-free: (800) 252-8039 (TTY: 711) Nurseline: (800) 581-0368	**www.healthselectoftexas.com**
Consumer Directed HealthSelect			
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 Health System Group number – 0010180000	Toll-free: (877) 698-7032 (TTY: (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**

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 higher monthly premium.

In March, the ERS Board of Trustees voted to update the definition of tobacco in ERS' tobacco policy to include electronic cigarettes and vaping products. If you use 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 online 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 charge after September 1.

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 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).

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.

ERS®
EMPLOYEES RETIREMENT SYSTEM OF TEXAS

COBRA SUMMER ENROLLMENT FORM

You may either enter your changes using your online account at **www.ers.texas.gov** or send this completed form to:
Employees Retirement System of Texas
P.O. Box 13207
Austin, Texas 78711-3207
(866) 399-6908 Toll-free

If you do not need to make any changes, it is not necessary to complete this form or contact ERS.

Information provided to the ERS is maintained for managing your benefits.
If you have questions about your information, or believe that information provided to ERS may be incorrect, please notify ERS.

SECTION A: COBRA PARTICIPANT DATA *(To be completed by the COBRA participant.)*

COBRA Participant Name: First, MI, Last	Last 4 digits of Social Security Number/National ID (SSN)	Phone Number ☐ Home ☐ Cell
	XXX-XX-	( )

Email Address	Mailing Address ☐ Check if New	City	State	ZIP Code	Eligibility County

SECTION B: INSURANCE COVERAGE *(Mark boxes to indicate the coverage changes you want starting September 1, 2019.)*

Medical Coverage	☐ Waive* ☐ HealthSelect of Texas® ☐ Consumer Directed HealthSelect℠
	☐ HMO Name ______________________________
	☐ Enroll/Add/Drop** Dependent (See Section C)
Optional Benefits *(May be elected without being enrolled in health coverage.)*	
Dental	☐ Waive ☐ State of Texas Dental Choice Plan℠ ☐ DeltaCare USA DHMO ☐ Enroll/Add/Drop Dependent (See Section C)
Vision	☐ Waive ☐ State of Texas Vision ☐ Enroll/Add/Drop Dependent (See Section C)

Tobacco-User Certification: If you are enrolled in a Texas Employees Group Benefits Program (GBP) health plan, have you used any type of tobacco product five or more times in the last three months? This includes but is not limited to cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, dip, and all e-cigarettes / vaping products. ☐ Yes ☐ No

*COBRA participants who waive coverage may not re-enroll at a later date.
**If a dependent drops medical coverage they cannot re-enroll at a later date.

SECTION C: DEPENDENT PERSONAL DATA *(and coverage choices.)*

Dependent Tobacco-User Certification: If your dependents are enrolled in a GBP health plan, you must certify below if your dependent used any type of tobacco product five or more times in the last three months. This includes but is not limited to cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, dip, and all e-cigarettes / vaping products.

Dependent Relationship*	Dependent's Name (First, MI, Last)	Gender	Date of Birth (mm-dd-yyyy)	Dependent SSN (Required for 12 months or older)	Health**	Dental	Vision	Tobacco User
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F		XXX-XX-	☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F		XXX-XX-	☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F		XXX-XX-	☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F		XXX-XX-	☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F		XXX-XX-	☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

*Relationship Code: Sp – Spouse D or S - Natural or adopted daughter or son O – Other than natural or adopted child. Includes stepchild, foster child, or ward child. If you are adding a child, you must complete a **Dependent Child Certification** form (ERS GI 1.081) available at **www.ers.texas.gov** or call ERS.
**If a dependent drops medical coverage they cannot re-enroll at a later date.

SECTION D: AUTHORIZATION *(Carefully read the statements below before you sign and date.)*

I authorize the appropriate deductions from my annuity or through bank draft for the benefits selected above, if applicable. If I do not receive an annuity or if my annuity is not sufficient to cover the necessary deductions, I agree to make premium payments when due. I understand that coverage will be cancelled if I do not pay the required premiums. I authorize any provider to release any information on persons covered when needed to verify eligibility or to process an insurance claim or complaint. **I certify all information provided above is valid and true to the best of my knowledge. I understand I may be asked to show documentation to support my selection, and/or to prove eligibility for any newly added dependents.** False information could lead to expulsion from the Texas Employees Group Benefits Program (GBP) and/or criminal prosecution.

Notice about Insurance: Funding for health and other insurance benefits for participants in the GBP is subject to change based on available state funding. The Texas Legislature determines the level of funding for such benefits and has no continuing obligation to provide funding for those benefits beyond each fiscal year.

Tobacco User Certification: I certify my understanding and agreement to the following: "Tobacco Products" is defined as all types of tobacco, including but not limited to, cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, dip, and all e-cigarettes / vaping products and a "Tobacco User" is a person who has used any Tobacco Products five or more times within the past three consecutive months. If I (or any of my covered dependents): 1) have used Tobacco Products as a Tobacco User; or 2) start using Tobacco Products without notifying ERS, I will be subject to monetary penalties and may be terminated from participation in the GBP. Also, failure to notify ERS will constitute fraud. Under the penalties of perjury, the above information is true and correct. Providing or entering false information may disqualify me from continued coverage in the GBP. If I intentionally misrepresent material facts or engage in fraud, my coverage may be rescinded retroactively to the date of the misrepresentation or fraudulent act. In that event, I will receive thirty days notice before my coverage is rescinded. Further, if I or any of my covered dependents start using Tobacco Products without notifying ERS, I will be subject to monetary penalties and such failure to notify ERS will constitute fraud. If you certified yourself or any of your dependents as a tobacco user, you may be able to participate in Choose to Quit, an alternative to the tobacco user premium, if it is right for your health status and complies with your doctor's recommendations. For more information about this program, visit, **https://ers.texas.gov/About-ERS/Policies/Tobacco-Policy-and-Certification**.

If you previously certified yourself or any of your dependents as a tobacco user, and you or they have stopped using tobacco for three consecutive months, you must complete the Tobacco User Certification Form (ERS 2.933) available at **https://ers.texas.gov/PDFs/Forms/Tobacco_User_Certification_ERS2933.pdf**, or change the certification using your ERS OnLine account at **www.ers.texas.gov**.

I understand that if I as a COBRA participant waive my medical coverage, I cannot re-enroll in medical coverage at a future date. If all coverage is waived, medical and optional coverage, I cannot re-enroll at any future date.

Participant's Signature:_____ Date Signed:_____

(Parent or legal guardian may sign for minor child) (mm-dd-yyyy)