New Employee Benefits Guide

PLAN YEAR 2026

Sept. 1, 2025 – Aug. 31, 2026

For employees of:

Higher education institutions (except The University of Texas and Texas A&M University systems)

Community Supervision and Corrections Department

Teacher Retirement System

Texas Municipal Retirement System

Texas County and District Retirement System

Windham School District

ERS®
Employees Retirement System of Texas

A message from ERS Executive Director Porter Wilson

Congratulations on your new job! Let me be among the first to welcome you to public service.

As a State of Texas employee, you earn valuable benefits designed to enhance your wellness and help secure your future.

The decisions you make will affect your health care, financial security and take-home pay. **You must make some of these decisions within 30 to 60 days after your start date, not including your start date**. I encourage you to take time to read about your options in this guide so you can make informed choices during your first few weeks on the job. Then, make the most of your benefits to improve your health, your financial well-being and your peace of mind.

At the Employees Retirement System of Texas, we're proud to support excellence in public service by administering health insurance, retirement and other benefits to state higher education employees and their families. We're committed to supporting you as you serve your fellow citizens. This New Employee Benefits Guide provides the information you need to make the most of your insurance and related benefits. For more information, visit the ERS website at **www.ers.texas.gov**.

Sincerely,

Porter Wilson
Executive Director
Employees Retirement System of Texas

The New Employee Benefits Guide for Plan Year 2026 highlights benefits that are effective at the time of publication. All Texas Employees Group Benefits Program (GBP) benefits could change without notice. The Texas Legislature decides the funding level for GBP benefits and has no obligation to provide for them beyond each fiscal year.

ERS offers competitive benefits to enhance the lives of its members.

Employees Retirement System of Texas

Always available online at **www.ers.texas.gov**

24/7 access to information about insurance and retirement benefits

To speak to a representative, call (877) 275-4377 (TDD: 711), Monday – Friday, 8 a.m. – 5 p.m. CT.

August 2025

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Go Online

For a quick overview of your new employee benefits, visit **ers.texas.gov → New employees**

Signing up for your benefits

As a State of Texas employee, ERS will automatically enroll you in:

- **HealthSelect of Texas®**, a point-of-service health plan, which includes prescription drug coverage. Automatic enrollment in health insurance applies only to full-time employees.
- **$5,000 Basic Term Life and accidental death and dismemberment (AD&D) insurance.** This comes automatically with your health insurance at no cost to you if you are a full-time employee. (Part-time employees who enroll in health insurance pay half the cost of their Basic Term Life and AD&D insurance.)

You have a choice

If you don't want to enroll in HealthSelect of Texas, you may choose Consumer Directed HealthSelect℠, a high-deductible health plan and tax-free health savings account (HSA) with a monthly HSA contribution from the State of Texas.

You can also enroll in these following optional benefits:

- one of two dental insurance plans;
- State of Texas Vision℠ insurance;
- additional life insurance for you and/or your eligible dependents;
- additional AD&D insurance;
- short-term and/or long-term disability coverage through the Texas Income Protection Plan℠ (TIPP);
- TexFlex℠ flexible spending account(s) (FSA) to lower your taxes while saving for certain expenses; and/or
- if your institution participates, a Texa$aver℠ 457 account.

A note to full-time employees

Unless you opt out of health coverage or select another plan, ERS will automatically enroll you in HealthSelect of Texas. You can change health plans or enroll in a TexFlex health care or limited-purpose FSA during your health coverage waiting period (60-90 days), but your participation won't begin until the end of your health coverage waiting period. You have 30 days after your start date (not including your start date) to sign up for optional benefits. If you miss this deadline, you will have to wait until the Summer Enrollment period or until you experience a qualifying life event, such as marriage, divorce, moving or a new child. If you wait to sign up, coverage in some plans is not guaranteed.

Benefits checklist

Within 30 days of your start date (not including your start date)

Enroll yourself and your eligible dependents in optional coverage. You cannot enroll your dependents in any coverage that you're not enrolled in.

☐ Dental insurance – coverage for you and your family

- DeltaCare® USA dental health maintenance organization (DHMO) or
- State of Texas Dental Choice Plan℠ preferred provider organization (PPO)

☐ Vision insurance – coverage for you and your family

- State of Texas Vision

☐ Optional Term Life Insurance – coverage for yourself

- Coverage at 1 or 2 times your annual salary
- Coverage at 3 or 4 times your annual salary, through evidence of insurability (EOI)

☐ Voluntary Accidental Death and Dismemberment (AD&D) Insurance – coverage for you and your family

- $10,000 – $200,000 for yourself or for yourself and your family

☐ Dependent Term Life Insurance – coverage for your family

- Coverage for eligible dependents

☐ Texas Income Protection Plan (TIPP) – coverage for you

- Short-term disability insurance
- Long-term disability insurance

☐ TexFlex dependent care flexible spending account (FSA)

- Reimburses you for eligible costs for child (under age 13) and adult care while you're at work
- For information on health care or limited-purpose flexible spending accounts (FSAs), please see the TexFlex entry under "Within 60 days of your hire."

Note: If you opt out and have other group health insurance that is comparable to ERS' health insurance, you can get a Health Insurance Opt-Out Credit to apply toward premiums for dental, vision and/or Voluntary AD&D Insurance.

Within 60 days of your hire

☐ Health insurance

If you are a full-time employee subject to a health insurance waiting period, change your health insurance from HealthSelect of Texas to one of the following options:

- Consumer Directed HealthSelect (and don't forget to open an Optum Bank health savings account) or
- opt out of or waive health coverage.

If you are a part-time employee, enroll yourself in:

- HealthSelect of Texas or
- Consumer Directed HealthSelect.

Enroll eligible dependents in the same plan you're enrolled in.

- Complete dependent child certification and begin the dependent eligibility verification process. See page 5.

☐ Certify tobacco-use status for yourself and any covered dependents.

See page 15.

☐ TexFlex health care or limited-purpose FSA

- Health care FSA for out-of-pocket health care expenses not covered by insurance (not available to Consumer Directed HealthSelect participants)
- Limited-purpose FSA for eligible dental and vision expenses not covered by insurance (available only to Consumer Directed HealthSelect participants)

Note: Your dependents don't need to be enrolled in your health insurance for you to set up flexible spending accounts and submit claims for their expenses.

At any time

☐ Texa$aver voluntary retirement savings account(s)

- Open a 457 account if your institution participates.
- Adjust your 457 account contribution amount.
- Change your 457 account investments.

☐ Add and update beneficiaries for:

- Life insurance
- Texa$aver
- Health savings account (if enrolled in Consumer Directed HealthSelect)

Frequently asked questions (FAQs)

When will my benefits start?

Your benefits begin based on the date you start work, when you enroll and the benefits you choose. See page 7 of this guide for detailed information about important dates and when your coverages take effect.

If I'm transferring from one state higher education institution to another, do I need to re-enroll in insurance benefits?

Yes. As part of your onboarding, your new institution will need to re-enroll you and will ask you to make your health insurance and optional benefits elections.

What happens if I don't make my health insurance elections within 60 days of my start date and elections for other benefits within 30 days after my start date (not including my start date)?

As a new employee with a health coverage waiting period, you have 30 days after your start date (not including your start date), to enroll in optional benefits and 60 days to decide on health insurance. See the Benefits Checklist on page 3 of this guide for more information.

If you don't enroll in most optional plans within 30 days after your start date (not including your start date), or decide on health insurance within your first 60 days, you must wait until Summer Enrollment or until you have a life change (also called a qualifying life event). If you do not enroll in optional plans within 30 days after your start date (not including your start date), you may be required to submit evidence of insurability (EOI) for certain optional insurance plans, and coverage is not guaranteed. See pages 5 and 27 of this guide for detailed information on EOI.

What's the most important thing to know about coverage for my dependents?

There are many important details to know about dependent eligibility. See the Dependent Coverage and Eligibility information on pages 5–6 of this guide. You can also find GBP eligibility information on the ERS website at **ers.texas.gov → Benefits at a Glance → GBP Eligibility** and **ers.texas.gov → Benefits at a Glance → GBP Eligibility → Eligibility Requirements**.

Are there resources to help me estimate monthly costs for my insurance options?

Yes. Find premium rates and plan comparison charts in this book and on the ERS website at **ers.texas.gov → Active Employees → Rate Calculator**. The website also has a helpful rate calculator.

What is "cost sharing"?

As your employer, the State of Texas currently covers more than two-thirds of health care costs for all ERS health insurance. Plan participants share the rest of the health costs through copays, coinsurance, prescription and/or medical deductibles, and premium payments for dependents, part-time employees and retirees who don't get the state's full premium contributions. In addition to designing health plans in which the state and participants share costs, ERS makes every effort to keep administrative expenses low and manage health care cost inflation for members. For a quick explainer, watch the "Cost sharing and how it works" video at **https://youtu.be/8X2EFNup580**.

Where can I find more FAQs?

Visit the Frequently Asked Questions page on the ERS website at **ers.texas.gov → Contact ERS → Additional Resources → FAQs**.

IMPORTANT: Enroll in valuable coverage within 30 days after your start date, no questions asked
If you want optional life insurance at one or two times your annual salary, Dependent Term Life Insurance and/or TIPP disability insurance, now is the best time to sign up. If you enroll within 30 days after your start date (not including your start date), you or your eligible dependents will not need to provide evidence of insurability (EOI). EOI is an application process that requires you to provide information about your or your dependents' health.

If you wait, you will have to apply for these benefits through EOI and run the risk of not qualifying based on your results. Don't miss this 30-day window of opportunity! (**Note:** Optional life insurance at three or four times your annual salary always requires EOI, even in your first month of employment.)

After your first 30 or 60 days of employment (not including your start date), you can make benefit changes only during Summer Enrollment unless you have a qualifying life event—for example, you get married or divorced, or you have a child. However, you must make benefit changes within 30 days after that life event, not counting the day of the event.

EXAMPLE: Your spouse can now provide health insurance for your child, starting Jan. 1. You will have until Jan. 31 to drop your child from your plan.

EXCEPTION: If your child loses Medicaid or CHIP eligibility, you will have 60 days to enroll them for GBP health coverage.

Dependent coverage and eligibility

Your spouse and other eligible dependents can get health insurance and other coverage for an additional premium. However, you must enroll in a health, dental and/or vision plan before you can enroll your dependents.

Your dependents must meet certain criteria to be eligible. Please see the dependent eligibility chart on page 6.

You can also go online at **ers.texas.gov → Active Employees → New Employees → Insurance Eligibility** to learn more about who qualifies for GBP insurance coverage.

If you want to enroll eligible dependents in Dependent Term Life Insurance, now is the best time to sign up. Your dependent will not need to provide evidence of insurability if you sign them up within your first month of employment.

Certifying dependent children

If you enroll a child or children through your ERS OnLine account, you'll have to certify each one before you submit your enrollment elections.

If you enroll your children with help from your benefits coordinator/HR department or the HHS Employee Service Center, you must fill out, sign and return the Dependent Child Certification form. Get the form:

- from your benefits coordinator/HR department or the HHS Employee Service Center or
- at **ers.texas.gov → Active Employees → Rates and Forms**. Scroll down until you see the link to the Dependent Child Certification form. You can fill it out online and print it, or you can print it and write the information in ink.The certification is legally binding. If you submit false information, you and your dependents could lose your benefits or be subject to other penalties.

Verifying all dependents enrolled in health insurance

Once ERS processes your dependents' enrollment in health coverage, third-party administrator Alight Solutions will contact you. ERS works with Alight Solutions to verify your dependents are eligible to participate in GBP plans.

Alight Solutions will mail you a letter that outlines the steps in the dependent verification process. The letter will list the names of the dependents to be verified, the documents needed to verify them and your deadline for sending in those documents.

Important: If you get a letter from Alight Solutions, open it right away! Be sure to carefully review all the information and keep the deadline in mind. If you don't send the right documents or you send documents after the deadline, your dependents may be found ineligible and dropped from all coverage. Your next chance to enroll dependents will be during Summer Enrollment. You should get your Summer Enrollment guide in your mailbox in June or July.

If you have questions about verifying your dependents, call Alight Solutions toll-free at **(866) 416-4091 (TTY: 711)**.

Please note: If both you and your spouse work for the State of Texas and enroll in separate GBP health plans, each of you will have a separate total out-of-pocket maximum and, if applicable to your plan, a separate annual deductible. Consider enrolling your dependents in coverage under the member who is more likely to meet the total out-of-pocket maximum and/or, if applicable, the deductible. For more information on out-of-pocket maximums and deductibles, see pages 10–11 and 14.

Dependent eligibility chart

Make sure your dependents are eligible for insurance and you have the appropriate documentation to show eligibility before you enroll them in any coverage. If you are unable to provide the documents listed below, please contact Alight Solutions Customer Service toll-free at **(866) 416-4091 (TTY: 711)**. Find more details at **ers.texas.gov → New Employees → Dependent Eligibility Verification**. False information can lead to removal from ERS insurance and/or criminal prosecution.

Note: You must provide a birth certificate to enroll a child. Alight Solutions will accept a hospital-issued birth certificate for a child age three months or younger.

Dependent of the Participant (employee, retiree or other individual enrolled in the GBP program as recognized by Texas law)	**Eligibility**	**Examples of Supporting Documents** (these documents are required)

Spouse	Spouse as recognized by law	• Government-issued marriage certificate **AND**
		  • Current federal tax return **OR**
		  • Proof of joint ownership** issued within last six months **OR**
		  • Government-issued marriage certificate only (if married in the last 12 months)

Common Law Spouse	Spouse as recognized by law	• Declaration of informal marriage filed with the appropriate government agency
		AND
		• One of the following:
		  – Current federal tax return or
		  – Proof of joint ownership** issued within last six months

Biological Child*	Natural-born child	• Government-issued birth certificate (see note above)

Adopted Child*	Child is eligible at time of placement.	• One of the following:
		  – Adoption certificate or
		  – Adoption placement agreement or
		  – Petition for adoption
		Note: Adoption documentation must state that the child has been placed with the member and include the date of the placement.

Stepchild*	Child is not required to live in participant's household.	• One of the following:
		  – Government-issued marriage certificate or
		  – Declaration of informal marriage filed with the appropriate government agency
		AND
		• Child's government-issued birth certificate
		AND
		• One of the following:
		  – Current federal tax return or
		  – Proof of joint ownership** issued within last six months

Child of Managing Conservator*	Child is identified in the managing conservatorship granted to the participant.	• Managing conservatorship court document signed by judge
Foster Child*	Child must not have other governmental insurance.	• Placement order **AND** • Affidavit of foster child
Legal Ward Child*	Child is under the protection or in the custody of the participant.	• Court order signed by a judge appointing participant as the child's guardian (documentation of legal custody) **AND** • Government-issued birth certificate
Other Child*	Child is related to participant by blood or marriage, was claimed as dependent on participant's federal income tax return for previous tax year, and will continue to be claimed on participant's federal income tax return for every calendar year the child is covered. A child who is acquired or born in the current calendar year will be claimed and continue to be claimed on participant's federal income tax return for every calendar year the child is covered.	• Government-issued birth certificate (see note above) **OR** • Government-issued marriage license to prove family relationship **AND** • Current federal tax return **OR** • Affidavit of good cause

*Child must be under age 26 for health insurance, and can be married or unmarried. Child must be under age 26 and unmarried for dental insurance, State of Texas Vision and Dependent Term Life Insurance. Disabled dependent children age 26 and over may be eligible for insurance. For more information, visit **ers.texas.gov → Active Employees → Life Changes → Children → Disabled Dependent Child**.

**See Alight Solutions' Documentation Requirements for examples of Joint Ownership documents.

When do my insurance benefits start?

First day of employment

Coverage for your optional benefits—dental, vision, optional life insurance elections 1 and 2, dependent life, Voluntary AD&D, TIPP disability insurance and/or a TexFlex dependent care FSA—could begin right away if you enroll on your first day.

First of the month following your start date

If you don't enroll in the optional benefits above on your first day, but within 30 days after your start date (not including your start date), coverage begins on the first day of the month after you added the coverage.

For example, if you start work at a state agency on Oct. 1, you will have until Oct. 31 to sign up for optional benefits such as (but not limited to) dental insurance and State of Texas Vision insurance, and to enroll eligible family members in coverage they're eligible for. Coverage will begin on Nov. 1.

Note: For optional life insurance elections 3 and 4, coverage begins the first of the month after you are approved through EOI. Learn more about EOI on page 27.

First of the month after 60 days of employment

Health insurance coverage, prescription drug coverage and, if you elect it, a TexFlex health care or limited-purpose FSA become active on the first day of the month following your 60th day of employment. If your 60th day of employment falls on the first of the month, coverage begins on that day.

For example, if you are hired on March 2, your 60th day will be May 1. Your health coverage, prescription drug coverage and/or TexFlex health care or limited-purpose FSA become active on May 1—you don't have to wait until June 1. If your hire date falls later in the month, your coverage begins the first day of the month after your 60th day of employment. For example, if you are hired on March 23, your coverage will begin on June 1.

This waiting period does not apply to your medical coverage, prescription drug coverage and TexFlex health care or limited-purpose FSA if you:

- transferred from one state agency or higher education institution that participates in the Texas Employees Group Benefits Program (GBP) to another GBP agency or institution without a break in GBP health coverage,
- transferred from the University of Texas or Texas A&M University system without a break in health coverage,
- are a return-to-work retiree enrolled in GBP health coverage as a retiree,
- are enrolled in GBP health coverage as a dependent on the date of hire or rehire,
- are enrolled in GBP health coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) on the date of hire or rehire, or
- were rehired on or after Sept. 1, 2015 and returned to employment at the same state agency within 90 days of leaving active military duty.

If you are in one of the categories above, please notify your HR department within 30 days after your start date (not including your start date) to start receiving your health benefits. For those starting mid-month, coverage under your new employer begins the first of the next month.

If you do not have a waiting period, you will have 30 days after your start date (not including your start date) to make health coverage changes. Those changes will begin the first day of the next month after you added the coverage. However, if you transferred as an employee from one GBP entity to another with no break in service, start your job on the first day of the month and change your health coverage that day, the change takes place immediately.

Dependent care FSA enrollment and funds

If you enroll in a dependent care FSA on your hire date, your enrollment begins on that day. If you don't enroll on your first day, but within 30 days after your start date (not counting your start date) or because of a qualifying life event, your enrollment begins on the first day of the month after you added the coverage. Funds won't be available in your dependent care FSA until they are deposited from your first paycheck after you enrolled. For example, if you adopt a child on Oct. 4 and enroll in a dependent care account, your enrollment would begin on Nov. 1. Your November contribution will be deducted from your November paycheck that you receive on Dec. 1 and be available for use once it is deposited into your account.

Return-to-work retirees

If you are a return-to-work retiree, you can switch between retiree and active benefits by contacting your benefits coordinator or human resources department.

Set up an ERS OnLine account

With an ERS OnLine account, you can check your coverage, update contact information and do other benefits-related activities at any time of the day or night, without having to call or visit ERS. Follow these steps to set up an account:

1. Go to **ers.texas.gov → My Account Login**.
2. Click on **Register Now**.
3. Enter your information and create a username and password.

Because you are a new employee, your benefits coordinator will likely enroll you and your dependents in the coverage you choose. You will be able to update your elections on your own during the next Summer Enrollment period with your ERS OnLine account.

Don't forget to update your ERS OnLine account if you move or have other life changes. Sign up for ERS news and updates at **ers.texas.gov → Contact ERS → Additional Resources → Subscribe**.

Log in to your ERS OnLine account

ERS requires two-factor authentication (2FA) for all ERS OnLine accounts. This security method means you'll use two verification steps when logging in to your account.

- After you enter your ERS OnLine username and password, you will be prompted to have a unique code emailed or texted to you.
- Enter the code to gain access to your ERS OnLine account.

What is the GBP?

Employees of State of Texas agencies and many higher education institutions can participate in the Texas Employees Group Benefits Program (GBP). Created by the Texas Legislature in 1991, the GBP offers insurance and related benefits that help State of Texas employees and their families live healthy, financially secure lives.

You are a member of the GBP while you're employed at:

- a state agency,
- a Texas public institution of higher education that is not part of The University of Texas or Texas A&M University systems,
- the Community Supervision and Corrections Department (CSCD),
- the Teacher Retirement System of Texas (TRS),
- the Windham School District,
- the Texas Municipal Retirement System (TMRS) or
- the Texas County and District Retirement System (TCDRS).

DISCOUNT Purchase Program administered by BENEPLACE

You are also eligible for discounts on a variety of products and services offered through the Discount Purchase Program, administered by Beneplace. There are no fees or membership requirements. Visit **ers.texas.gov → Active Employees → Optional Add-on Benefits → Discount Purchase Program** for more information.

Understand your health plan options

Choosing the right health insurance for you and your family is an important decision. You have a responsibility to understand how the benefits you choose could affect your family's health and finances.

As a State of Texas higher education employee, you can choose HealthSelect of Texas or Consumer Directed HealthSelect.

Both health plans are network-based. This means you'll save money—sometimes a lot of money—if you go to doctors and other providers in the plan's network. The two HealthSelect plans have a large network of primary care providers (PCPs), specialists, mental health professionals, hospitals and other providers across Texas.

Both plans require cost-sharing. You and the State of Texas, as your employer, both pay for coverage and care. The state pays 100% of the monthly premium for eligible full-time employees and 50% of the premium for their eligible dependents. The state pays 50% of the premium for eligible part-time employees and 25% of the premium for their eligible dependents.

You may also pay out of pocket for some of your care—through copays, coinsurance, deductibles for prescriptions, and in some cases, deductibles for medical care. How much you pay out of pocket depends on the plan you choose and, once you're enrolled, the providers you see.

Which plan is best for you and your family? The table below shows key features of each plan. You can also use the decision tool at **healthselect.bcbstx.com → Medical Plans and Benefits → HealthSelect Plans**. Part-time and dependent premium information is on page 34.

Health insurance plan features at a glance	HealthSelect of Texas	Consumer Directed HealthSelect
Participants pay for non-preventive doctor visits with:	Copays	Coinsurance, after meeting the annual deductible
Large statewide and nationwide networks	✓	✓
Tax-advantaged health savings account (HSA) with monthly contributions from state		✓
Referrals required for most care	✓	
In-network preventive care covered at 100%	✓	✓
Prescription drug coverage	✓	✓
Lower monthly premium		✓
You must reach combined medical and prescription drug deductible before the plan starts paying for non-preventive care		✓
Primary care provider required	✓	
Save money by seeing in-network providers	✓	✓

For a more detailed view of coverage, see the Health Plans Comparison Chart online at **ers.texas.gov → Active Employees → Rate Calculator**.

HealthSelect of Texas and Consumer Directed HealthSelect

You can choose between HealthSelect of Texas and Consumer Directed HealthSelect. With both plans, you have access to a large network of medical and mental health providers in Texas. Blue Cross and Blue Shield of Texas (BCBSTX) manages the provider network, processes claims and provides customer service. Both plans include a comprehensive prescription drug program.

HealthSelect of Texas®

Key features of HealthSelect of Texas:

- You do not have to meet an annual medical deductible if you use providers in the HealthSelect network. If you get care outside the network, you will have to meet a $500 annual deductible per person, with a maximum annual deductible of $1,500 per family.
- You have prescription drug coverage, which includes a $50 per person deductible before the plan begins to pay for prescription drugs. This deductible resets at the beginning of each calendar year from Jan. 1 to Dec. 31. (The plan year for health benefits and premiums follows the state's fiscal year calendar from Sept. 1 through Aug. 31.) See page 14 for more information about the HealthSelect℠ Prescription Drug Program.
- You are responsible for copays and/or coinsurance for doctor and hospital visits and other medical services, such as outpatient surgery and high-tech radiology.
- You need to choose a primary care provider (PCP) on file with BCBSTX and get referrals from your PCP to see some in-network specialists. After the first 60 days in the plan, if you do not choose a PCP, you will have out-of-network coverage until you choose one, even if you see in-network providers. A PCP helps keep your costs as low as possible, while ensuring you get the care you need.
- If you do not have a referral from your PCP on file with BCBSTX before you get treatment from some specialists, you could pay more for your treatment, even if the specialist is in the HealthSelect network.

You do not need a referral for:

- Chiropractic visits
- Dermatology visits
- Eye exams (both routine and diagnostic)
- Mental health services
- OB-GYN visits
- Occupational therapy, speech therapy and physical therapy
- Virtual Visits through Doctor on Demand® or MDLIVE® for medical or mental health care
  - Virtual Visits for medical and mental health care are covered at no cost for HealthSelect of Texas participants.
- Urgent care centers and convenience care clinics

Please note:

- You must select a primary care provider (PCP) if you enroll in HealthSelect of Texas. If you don't choose a PCP, you may end up paying more—possibly a lot more—for services.
- If you are in HealthSelect of Texas and need to see a specialist (that is, someone other than your PCP), you will need a referral from your PCP on file with BCBSTX to see a specialist and receive in-network benefits.
- You do not need to designate a PCP or get referrals to specialists if you enroll in Consumer Directed HealthSelect, or if you enroll in HealthSelect℠ Out-of-State.

CONSUMER DIRECTED
HealthSelect℠

Consumer Directed HealthSelect is a high-deductible health plan (HDHP) 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 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 any part of Medicare.

Key features of Consumer Directed HealthSelect:

- You do not need to designate a PCP or get referrals to specialists.
- The monthly dependent/part-time premium is lower than HealthSelect of Texas, but you pay the full cost of doctor visits, prescriptions, hospital stays and any other non-preventive health services or products until your annual deductible is met.
- You get a monthly HSA contribution from the state to help pay for eligible medical costs. (See information on HSAs on page 12.)
- After you meet the deductible, you pay coinsurance (20% in-network, 40% out-of-network) for medical services and prescriptions, rather than a copay.
- You have prescription drug coverage. See pages 14 and 20 for more information about the Consumer Directed HealthSelect Prescription Drug Program.
- Your deductible and total out-of-pocket maximums for individual and family coverage reset on Jan. 1. (The plan year for premiums and health benefits follows the state's fiscal year calendar – September through August.)

For more information on Consumer Directed HealthSelect, see **ers.texas.gov → Contact ERS → Additional Resources → FAQs → High Deductible Health Plan**.

Consumer Directed HealthSelect annual deductibles

For Calendar Years 2025 and 2026 (includes prescription drugs)

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

Eileen Eiden

Understanding the HDHP with HSA

When Eileen Eiden joined Austin Community College in 2014, an HDHP wasn't among her health plan options. "I was surprised, and I kept asking when ERS would offer a high-deductible plan," Eiden recalled.

Two years later, when ERS began offering Consumer Directed HealthSelect, Eiden promptly signed up and found this HDHP with a health savings account (HSA) to be a good fit for her.

An HDHP "is perfect for healthy adults, especially if you see a doctor only once a year. Your in-network preventive care is fully covered, with no copay or coinsurance," Eiden explained. Then, there is the HSA. "It's like a 401(k), but for health."

The State of Texas contributes money to the HSA every month, if a Consumer Directed HealthSelect member opens an HSA with Optum Bank. Plus, GBP members can contribute their own pre-tax money. HSA funds are tax-free when spent on eligible health care expenses (even in retirement).

And, if you leave your job or retire, the money in your account—even the portion contributed by the state—is yours to keep. In time, the funds in an HSA can accumulate with contributions, earned interest and investment earnings. None of this growth is taxed when spent on eligible health care expenses.

Eiden acknowledged that plans like Consumer Directed HealthSelect might be risky for people who don't have enough cash to cover the plan's annual high deductible, which includes both covered pharmacy and medical costs. After they meet the deductible, the GBP member pays 20% coinsurance (not copays) for in-network health care services and prescription drugs. If you haven't saved enough in your HSA to meet the deductible, you could be faced with a financial challenge.

"What scared me the most was the possibility that I wouldn't be able to pay for my medical care," Eiden stated. "Once I started adding money to my HSA, that was no longer an issue."

Health savings account (HSA)

Available only with Consumer Directed HealthSelect

- An HSA allows you to set money aside, tax free, and use the funds to pay for eligible out-of-pocket health expenses anytime, even in retirement. (Once you reach age 65, you can even use your HSA for non-health expenses, but you'll pay taxes on any funds spent on non-health costs.)
- You can use your HSA funds, tax free, for qualified medical expenses for yourself, your spouse and eligible dependents—even if they're not covered under your health insurance.
- The Internal Revenue Service (IRS) defines qualified medical expenses. Visit **optumbank.com → Resources → Qualified Medical Expense Tool** for more information.
- To help cover your out-of-pocket health costs, the state makes a monthly contribution to the HSA of every eligible GBP member enrolled in Consumer Directed HealthSelect. You are not eligible to make or receive any contributions to an HSA if you are enrolled in Medicare or in certain other cases. (To learn more about HSA eligibility, visit **ers.texas.gov → Contact ERS → Additional Resources → FAQs → Consumer Directed HealthSelect Health Savings Account**) Contributions—both from the state and, optionally, a GBP member's paycheck—are usually available in the HSA by the middle of the next month.
- You can make pre-tax contributions to your HSA through payroll deductions. The IRS sets the maximum contribution amount each year. See the table below for maximum contributions.
- You can also make a contribution (or contributions) directly to your HSA. They would be after-tax contributions that you could claim when you file your tax return for the year.
- Member HSA contributions are voluntary. You do not have to contribute if you don't want to.
- All the money in your HSA carries over from one year to the next—there is no use-it-or-lose-it rule—and you can keep the funds if you change health plans or even leave state employment.

Contribute for TRIPLE TAX SAVINGS

1. Contribute money into the account tax free.
2. Pay for qualified medical expenses tax free.
3. Earn interest or investment growth on the account tax free.

For more information about HSAs, see **ers.texas.gov → Contact ERS → Additional Resources → FAQs → Consumer Directed HealthSelect Health Savings Accounts**.

HSA contributions and maximums*

Contribution	Individual Account	Family Account*
Calendar Year 2025 annual total maximum contribution (Jan. 1 – Dec. 31, 2025)	Up to age 54: $4,300 Age 55 and older: $5,300	$8,550
Calendar Year 2026 annual total maximum contribution (Jan. 1 – Dec. 31, 2026)	Up to age 54: $4,400 Age 55 and older: $5,400	$8,750
Fiscal Year 2026 annual state contribution (Sept. 1, 2025 – Aug. 31, 2026)	$540 ($45 monthly)	$1,080 ($90 monthly)

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

Note: HSA contributions and limits may change from year to year. They may also change 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. Contributions are based on the calendar year, and maximums reset Jan. 1.

Open your HSA

Enrolling in Consumer Directed HealthSelect? Open your HSA as soon as possible.

If you enroll in Consumer Directed HealthSelect, open your HSA as soon as possible, so the state's monthly contributions and any other funds can be deposited into your account. Optum Bank manages the ERS HSA program. Even if you don't plan to make your own pre-tax contributions, you must open an Optum Bank HSA to get the state's contributions. You can go to **optumbank.com/texasers** to open an account. Or, to get an application mailed to you, call Optum Bank toll-free at **(800) 791-9361**.

Like state paychecks, state HSA deposits are paid in arrears—that is, at the end of each month worked—so the state's HSA funds may be deposited in your account some time after the 15th of the month following the month worked. For example, if you elect Consumer Directed HealthSelect during Summer Enrollment and open your HSA by early September, the first state deposit into the account will typically occur two or three weeks after you get your Oct. 1 paycheck.

If you want to contribute to your HSA via payroll deduction, you must elect your payroll deductions through your ERS OnLine account—or your benefits coordinator can do it for you. (You don't to have to contribute to your HSA with payroll deductions, but it's a convenient and consistent way to make pre-tax contributions.) You can change your contributions any time during the year, as long as your and the state's total contributions don't exceed the IRS' contribution maximum for the calendar year.

Once you open your HSA, Optum Bank will send you a debit card to pay for eligible health expenses. You will have access only to the amount of money that has accumulated in your HSA, not any funds that are pledged to be deposited in the future.

Please note!

You can opt out of health insurance coverage—and get credit.

If you can certify that you already have health insurance that is equal to or better than that offered through ERS, you can sign up for a monthly health insurance Opt-Out Credit of up to $60 for full-time employees and $30 for part-time employees.

- The credit helps pay your dental, vision and/or Voluntary Accidental Death and Dismemberment insurance premiums.
  Note: No portion of the Opt-Out Credit will be refunded if the full Opt-Out Credit is not used for dental, vision and/or AD&D premiums.
- The 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 insurance coverage.

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

If you opt out of or waive ERS health coverage and later lose your other coverage, you can enroll in one of the health insurance plans offered through ERS. Losing coverage is a qualifying life event, and you will have 30 days after losing your other plan to enroll in an ERS health plan.

Lower your health care costs with HealthSelectShoppERS℠

HealthSelect of Texas, HealthSelect℠ Out-of-State and Consumer Directed HealthSelect participants can lower their health care costs and earn incentives with HealthSelectShoppERS. Shopping for lower-cost options for care can save you money on certain medical services or procedures and reward you with contributions to your TexFlex health care or limited-purpose flexible spending account (FSA). See page 39 or visit **healthselect.bcbstx.com → Medical Plans and Benefits → HealthSelectShoppERS** to learn more.

Prescription drug coverage

Your HealthSelect insurance plan includes coverage for prescription drugs. Express Scripts Inc. administers the HealthSelect Prescription Drug Program for both HealthSelect of Texas and Consumer Directed HealthSelect. You will get separate ID cards from Blue Cross and Blue Shield of Texas (for medical coverage) and Express Scripts (for prescription drug coverage). You may need to present your HealthSelect Prescription Drug Program ID card when filling a prescription.

Every participant in HealthSelect of Texas must pay an annual $50 deductible before the program begins to cover their prescription drug expenses. In Consumer Directed HealthSelect, participants must meet an annual combined medical and prescription drug deductible before the plan pays for anything except in-network preventive care. The deductible starts over each January.

Under the HealthSelect Prescription Drug Program, prescription drugs fall into three categories, called tiers, with different costs 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 will pay less for prescriptions if you use in-network pharmacies. To find out which pharmacies are in the network, visit **www.HealthSelectRx.com**.

Out-of-pocket limits on health expenses

To help protect you from extremely high health costs, the HealthSelect 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 for covered medical and prescription drugs. If you reach this maximum, the plan will pay 100% of covered in-network health and pharmacy expenses for the rest of the year. (There is no out-of-pocket maximum for out-of-network services.)

The out-of-pocket maximums reset every calendar year (on Jan. 1).

In-network out-of-pocket maximums (all plans)	
Calendar Year 2025 (Jan. 1 - Dec. 31, 2025)	**$8,050 individual** **$16,100 family** (GBP member + one or more covered family member)
Calendar Year 2026 (Jan. 1 - Dec. 31, 2026)	**$8,300 individual** **$16,600 family** (GBP member + one or more covered family member)

You must certify your status—whether you use tobacco or not

You must certify yourself and any covered dependents as tobacco users or non-users if you enroll in a GBP health insurance plan. Certified tobacco users pay a higher premium for their health coverage.

ERS' tobacco policy defines tobacco products as all types of tobacco, including but not limited to cigarettes, cigars, pipe tobacco, chewing tobacco, snuff and dip; and all electronic cigarettes and vaping products. Vaping products that do not contain tobacco or nicotine are also considered tobacco products.

A tobacco user is a person who has used any tobacco product, as defined above, five or more times within the past three consecutive months.

If you or a covered dependent uses tobacco products, you are required to certify yourself or your dependents as a tobacco user and pay the monthly tobacco user premium.

Note: You need to certify your status only once, unless your status changes. You can update your tobacco-use status through your ERS OnLine account, by phone or by returning the online Tobacco Use Certification form to ERS.

Ready to quit?

All HealthSelect℠ plans cover programs and prescription drugs that will help tobacco users quit. If a participant remains tobacco-free for three consecutive months, they can re-certify as a tobacco non-user and will no longer have to pay the higher premiums.

Tobacco user premium alternative

If you are a tobacco user, you may qualify for an alternative to the tobacco user premium, if it complies with your doctor's recommendations. For more information, see the ERS tobacco policy on ERS website at **ers.texas.gov → About ERS → Policies → Tobacco Policy and Certification** or contact ERS toll-free at **(877) 275-4377**.

Improve your health and lifestyle!

The tobacco cessation program is only one of the programs and tools your state benefits package offers to help you get healthier. Visit the HealthSelect website to find out more about the tobacco cessation and other wellness programs available to you.

If you or one of your covered family members uses tobacco products and you certify them as a non-user, or if you fail to update the tobacco-use status when you or a covered family member starts using tobacco products, you could lose your GBP health insurance coverage.

Health plans comparison chart

Employees and retirees not eligible for Medicare – Effective Sept. 1, 2025

These charts show your share of costs for commonly used medical, mental health, prescription drug and diabetes supply benefits in the HealthSelect of Texas® and Consumer Directed HealthSelect℠ plans. For in-depth information about eligibility, services that are covered and not covered, and how benefits are paid, view the Master Benefit Plan Documents (MBPDs) on your plan's website. If there is a conflict between the MBPD, MBPD Amendments and this chart, the MBPD and its Amendments will control.

Blue Cross and Blue Shield of Texas (BCBSTX) administers medical and mental health benefits in both plans. Mental health benefits apply to all covered mental/behavioral/substance use disorder services (including serious mental illness treatment, substance use disorder treatment, autism spectrum disorder services, etc.). Express Scripts manages prescription drug benefits for the plans. As administrators, they process claims and oversee the provider networks and drug formularies. ERS designs the benefits and pays the claims.

	HealthSelect of Texas®		Consumer Directed HealthSelect℠	
	HealthSelect of Texas® and HealthSelect℠ Out-of-State In-Network	**HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network**	**Consumer Directed HealthSelect℠ High-deductible Health Plan In-Network**	**Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network**
Administrator	**Blue Cross and Blue Shield of Texas (BCBSTX)**			
Annual deductible	None	$500 per individual $1,500 per family	$2,100 per individual, $4,200 per family To help cover part of the deductible, the State contributes to an eligible participant's health savings account: $540/year for an individual, $1,080/year for a family	$4,200 per individual, $8,400 per family To help cover part of the deductible, the State contributes to an eligible participant's health savings account: $540/year for an individual, $1,080/year for a family
Out-of-network benefits?		Yes. See next page for details.		Yes. See next page for details.
Balance billing? (Balance billing is when an out-of-network provider charges you the difference between their billed charges and the plan's allowed amount.)		Yes. Balance billing may apply to certain out-of-network services. For more information, see the plan's Master Benefit Plan Document.		Yes. Balance billing may apply to certain out-of-network services. For more information, see the plan's Master Benefit Plan Document.
Total in-network out-of-pocket maximum (including deductibles, coinsurance and copays)[1]	Jan. 1 – Dec. 31, 2025: $8,050 per person; $16,100 per family Jan.1 - Dec.31, 2026: $8,300 per person $16,600 per family		Jan. 1 – Dec. 31, 2025: $8,050 per person; $16,100 per family Jan.1 - Dec.31, 2026: $8,300 per person $16,600 per family	
Out-of-pocket coinsurance maximum	$2,000 per person	$7,000 per person	None	None
Inpatient copay maximum	$750 copay max, up to 5 days per hospital stay $2,250 copay max per calendar year per person		None	None
Primary care provider (PCP) required?	Participants who live and work in Texas: Yes Out-of-state participants: No	No	No	No
Referrals required?	Participants who live and work in Texas: Yes Participants who live out of state: No	No	No	No

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

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.

Health Plan Benefits

Service	HealthSelect of Texas® and HealthSelect℠ Out-of-State In-Network	HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network	Consumer Directed HealthSelect℠ High-deductible Health Plan In-Network	Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network
Allergy treatment	Covered at 100% if administered in a physician's office; 20% coinsurance in any other outpatient location	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Ambulance services (for emergencies)	20% coinsurance	20% coinsurance; annual deductible does not apply	20% coinsurance after annual deductible is met	20% coinsurance after annual in-network deductible is met
Ambulance services (non-emergencies*)	20% coinsurance	20% coinsurance; annual deductible does not apply	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Applied Behavioral Analysis (ABA) treatment*	Coverage is based on place of treatment. • $25 copay if administered in a mental health provider's office • 20% coinsurance for any other outpatient location, including the home	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Bariatric surgery* Additional eligibility requirements apply. See the MBPD for details.	• Deductible: $5,000 • Coinsurance: 20% • Lifetime max: $13,000	Not covered	Not covered	Not covered
Chiropractic care	• Without office visit: 20% coinsurance • With office visit: $40 copay plus 20% coinsurance • Maximum benefits of $75 per visit and maximum of 30 visits per calendar year	40% coinsurance after annual deductible is met. Maximum benefits of $75 per visit and maximum of 30 visits per calendar year	20% coinsurance after annual deductible is met. Maximum benefits of $75 per visit and maximum of 30 visits per calendar year	40% coinsurance after annual deductible is met. Maximum benefits of $75 per visit and maximum of 30 visits per calendar year
Cranial hair prosthetics (wigs)	20% coinsurance; limited to lifetime benefit max of $1,000. Out-of-network deductible does not apply.		20% coinsurance after annual deductible is met; limited to lifetime benefit max of $1,000.	
Diagnostic A1c testing (for participants diagnosed with diabetes)	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance; deductible does not apply	40% coinsurance after annual deductible is met
Diabetes equipment	20% coinsurance; see page 21 for details.	40% coinsurance after annual deductible is met; see page 21 for details.	20% coinsurance after annual deductible is met; see page 21 for details.	40% coinsurance after annual deductible is met; see page 21 for details.
Diabetes supplies	See page 21 for details.			
Diagnostic X-rays and lab tests	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Diagnostic mammography	Covered at 100%	40% coinsurance after annual deductible is met	Covered at 100%; subsequent scans after breast cancer is established are covered at 100% after annual deductible is met	40% coinsurance after annual deductible is met
Durable medical equipment	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Facility-based providers (radiologists, pathologists and labs, anesthesiologists, emergency room physicians, etc.)	20% coinsurance	Emergencies: 20% coinsurance; annual deductible does not apply. Non-emergencies: 40% coinsurance after annual deductible is met (Network benefits apply to services rendered by an out-of-network provider in a network facility.)	20% coinsurance after annual deductible is met	Emergencies: 20% coinsurance after annual in-network deductible is met. Non-emergencies: 40% coinsurance after annual out-of-network deductible is met. (Network benefits apply to services rendered by an out-of-network provider in a network facility.)

*It is recommended your provider submit a request to BCBSTX to confirm coverage, limitations and medical necessity prior to rendering services.

Service	HealthSelect of Texas® and HealthSelect℠ Out-of-State In-Network	HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network	Consumer Directed HealthSelect℠ High-deductible Health Plan In-Network	Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network
Facility emergency care (non-FSER) and hospital-affiliated freestanding emergency departments	$150 copay plus 20% coinsurance (If admitted, copay will apply to hospital copay.)	Emergencies: $150 copay plus 20% coinsurance (If admitted, copay will apply to hospital copay.) Annual deductible does not apply. Non-emergencies: $150 copay plus 40% coinsurance after annual out-of-network deductible is met.	20% coinsurance after annual deductible is met	Emergencies: 20% coinsurance after annual in-network deductible is met. Non-emergencies: 40% coinsurance after annual out-of-network deductible is met.
Freestanding emergency room facility	$150 copay plus 20% coinsurance	Emergencies: $150 copay plus 20% coinsurance; annual deductible does not apply. Non-emergencies: $150 copay plus 40% coinsurance after annual out-of-network deductible is met.	20% coinsurance after annual deductible is met	Emergencies: 20% coinsurance after annual in-network deductible is met. Non-emergencies: 40% coinsurance after annual out-of-network deductible is met.
Habilitation and rehabilitation services - outpatient therapy (including physical therapy, occupational therapy and speech therapy)	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Hearing aids (for covered participants over age 18)	Plan pays up to $1,000 per ear for any consecutive 36-month period and $1 per battery. In-network and out-of-network hearing aids are covered at the same benefit level.		20% coinsurance after annual in-network deductible is met. Plan pays up to $1,000 per ear for any consecutive 36-month period and $1 per battery. In-network and out-of-network hearing aids are covered a the same benefit level.	
Hearing aids (for participants 18 years of age and younger)	Plan pays 100%; limit of one hearing aid per ear for any consecutive 36-month period and $1 per battery. In-network and out-of-network hearing aids are covered at the same benefit level.		20% coinsurance after annual in-network deductible is met; limit of one hearing aid per ear per any consecutive 36-month period and $1 per battery. In-network and out-of-network hearing aids are covered at the same benefit level.	
High-tech radiology (CT scan, MRI and nuclear medicine)*	$100 copay plus 20% coinsurance	$100 copay plus 40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Home health care*	20% coinsurance	40% coinsurance after annual deductible is met Maximum 100 visits per calendar year (for out-of-network only)	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met. Maximum 100 visits per calendar year
Inpatient* and outpatient hospice and rehabilitation	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Inpatient hospital facility (medical and mental health semi-private room and day's board, and intensive care unit)*	• $150/day copay plus 20% coinsurance • $750 copay max, up to 5 days per hospital stay • $2,250 copay max per calendar year per person	• $150/day copay plus 40% coinsurance after annual deductible is met. • $750 copay max, up to 5 days per hospital stay • $2,250 copay max per calendar year per person	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Maternity care doctor charges only; inpatient hospital copays will apply	$25 or $40 copay for the visit to confirm pregnancy. No cost for subsequent routine prenatal, postnatal visits and obstetrician delivery services.	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met for the visit to confirm pregnancy. No cost for subsequent routine prenatal, postnatal visits and obstetrician delivery services.	40% coinsurance after annual deductible is met

*It is recommended that your provider submit a request to BCBSTX to confirm coverage, limits and medical necessity prior to rendering services.

Service	HealthSelect of Texas® and HealthSelect℠ Out-of-State In-Network	HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network	Consumer Directed HealthSelect℠ High-deductible Health Plan In-Network	Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network
Medications and injections administered by a provider (including specialty medications obtained through BCBSTX*)	• Physician's office: Covered at 100% after copay (or 100% if no charge is assessed for office visit) • Any other outpatient location: 20% coinsurance. • Preventive vaccines covered at 100%	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met Preventive vaccines covered at 100%	40% coinsurance after annual deductible is met
Mental health provider office visit	$25 copay	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Outpatient facility care (includes mental health partial hospitalization/day treatment and extensive outpatient treatment*)	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
PCP office visit	$25 copay	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Private duty nursing*	20% coinsurance	40% coinsurance after annual deductible is met Maximum of 96 hours per calendar year	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met Maximum of 96 hours per calendar year
Retail health/ convenience care clinic	$25 copay	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Routine eye exam, one per year per participant	$40 copay	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Routine preventive care	No cost to participant(s)	40% coinsurance after annual deductible is met	No cost to participant(s)	40% coinsurance after annual deductible is met
Skilled nursing facility/ inpatient rehabilitation facility services*	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Specialist physician office visit (non-mental health)	$40 copay with valid PCP referral on file	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Surgery in a physician's office	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Surgery (outpatient) other than in physician's office*	$100 copay plus 20% coinsurance	$100 copay plus 40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Telemedicine visit	Coverage is based on place of treatment billed. • Provider's office: $25/$40 copay for physician's office visit • Any other outpatient telemedicine: 20% coinsurance • ACA preventive services obtained by telemedicine are at no cost	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Therapeutic treatments - outpatient	20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Urgent care clinic	$50 copay plus 20% coinsurance	40% coinsurance after annual deductible is met	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Virtual Visits (medical and mental health)	$0 copay for virtual visits when provided by Doctor On Demand® or MDLIVE®	Not covered	20% coinsurance after annual deductible is met for virtual visits when provided by Doctor On Demand or MDLIVE	Not covered

*It is recommended your provider submit a request to BCBSTX to confirm coverage, limitations and medical necessity prior to rendering services.

Prescription Drug Benefits

The cost share you pay for your medication depends on its drug tier, the quantity you purchase (30-, 60- or 90-day supply) and whether the prescription is filled at a retail pharmacy (in-network or out-of-network), Extended Day Supply Pharmacy (EDS) or mail service pharmacy.

You will pay less for your drugs when you fill your prescription at an in-network pharmacy. The Express Scripts network includes thousands of retail locations, including national chains and many community pharmacies. To find an in-network pharmacy near you, use the Find a Pharmacy tool at **HealthSelectRx.com** or call an Express Scripts customer care representative toll-free at **(800) 935-7189 (TTY: 711)**.

Non-maintenance medications are those prescribed for temporary use or for short-term conditions. Maintenance medications are those taken more regularly for long-term conditions.

	HealthSelect of Texas® and HealthSelect℠ Out-of-State In-Network	HealthSelect of Texas and HealthSelect Out-of-State Out-of-Network	Consumer Directed HealthSelect℠ High-deductible Health Plan In-Network	Consumer Directed HealthSelect High-deductible Health Plan Out-of-Network
Pharmacy benefits manager (PBM)	Express Scripts			
Out-of-network benefits?		Yes		Yes
Deductible	$50 prescription drug deductible per participant per calendar year applies before the plan pays for any prescription drugs (except covered preventive medications, specific diabetic supplies (as listed on page 21) and insulin dispensed by an in-network pharmacy).		$2,100 per individual; $4,200 per family Medical and prescription drug expenses apply to the deductible.	$4,200 per individual; $8,400 per family Medical and prescription drug expenses apply to the deductible.
Tier 1 (mostly generic drugs)	Non-maintenance and maintenance (30 days' supply): $10 copay Mail order or extended day supply pharmacy (90 days' supply): $30 copay	Non-maintenance and maintenance (30 days' supply): $10 copay plus 40% coinsurance Mail order or extended day supply pharmacy (90 days' supply): $30 copay plus 40% coinsurance	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Tier 2 (mostly preferred brand name drugs)*	• Non-maintenance (30 days' supply): $35 copay • Maintenance (30 days' supply): $45 copay • Mail order or extended day supply pharmacy (90 days' supply): $105 copay	• Non-maintenance (30 days' supply): $35 copay plus 40% coinsurance • Maintenance (30 days' supply): $45 copay plus 40% coinsurance • Mail order or extended day supply (90 days' supply): $105 copay plus 40% coinsurance	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Tier 3 (mostly non-preferred brand name drugs)*	• Non-maintenance (30 days' supply): $60 copay • Maintenance (30 days' supply): $75 copay • Mail order or extended day supply pharmacy (90 days' supply): $180 copay	• Non-maintenance (30 days' supply): $60 copay plus 40% coinsurance • Maintenance (30 days' supply): $75 copay plus 40% coinsurance • Mail order or extended day supply pharmacy (90 days' supply): $180 copay plus 40% coinsurance	20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met
Specialty drugs*	If purchased through a pharmacy, specialty drugs are covered at the specific tier level (generic, preferred or non-preferred) as listed above. Otherwise, they are covered as a medical benefit.		20% coinsurance after annual deductible is met	40% coinsurance after annual deductible is met

*Prior Authorization may be required.

Diabetes Equipment and Supplies

Other diabetes equipment, supplies, and prescription drugs not listed below may be covered under these plans. For more information about your prescription drug benefits or for help finding an in-network pharmacy, contact HealthSelect Prescription Drug Program customer care toll-free at **(800) 935-7189 (TTY: 711)**. For more information on your medical plan benefits, contact a BCBSTX Personal Health Assistant toll-free at **(800) 252-8039 (TTY: 711)**.

	HealthSelect of Texas® and HealthSelect℠ Out-of-State		Consumer Directed HealthSelect℠	
	Prescription Drug Program (PDP) benefits	**Medical plan benefits**	**Prescription Drug Program (PDP) benefits**	**Medical plan benefits**
Diabetes equipment - glucometers	Certain brands of preferred glucometers are covered at no cost to participants when received through the free glucometer program*. For more information on the free glucometer program, call Express Scripts.	Refer to Prescription Drug Program (PDP) benefits	Certain brands of preferred glucometers are covered at no cost to participants when received through the free glucometer program*. For more information on the free glucometer program, call Express Scripts.	Refer to Prescription Drug Program (PDP) benefits
Diabetes equipment - Continuous glucose monitors / insulin pumps	Certain brands of continuous glucose monitors and related supplies	20% coinsurance for in-network and 40% coinsurance for out-of-network covered continuous glucose monitors and insulin pumps through durable medical equipment benefits.	Certain brands of continuous glucose monitors and related supplies	20% coinsurance for in-network and 40% coinsurance for out-of-network covered continuous glucose monitors and insulin pumps through durable medical equipment benefits.
Diabetic supplies	Certain brands of preferred diabetic test strips* are covered at no cost to participants when purchased from a PDP in-network pharmacy. Lancets and lancing devices, and syringes are covered at no cost to participants when purchased from a PDP in-network pharmacy.	20% coinsurance for in-network and out-of-network diabetic supplies used exclusively with a provider prescribed continuous glucose monitor or insulin pump. For all other diabetic supplies, refer to PDP benefits.	20% coinsurance for covered diabetic supplies after annual in-network deductible is met when purchased from a PDP in-network pharmacy 40% coinsurance after annual out-of-network deductible is met when purchased from a PDP out-of-network pharmacy	20% coinsurance for in-network and out-of-network diabetic supplies used exclusively with a provider prescribed continuous glucose monitor or insulin pump. For all other diabetic supplies, refer to PDP benefits.
Prescription insulin	In-network pharmacy: Insulin products on the PDP drug list (formulary) are covered with a maximum $25 copay per 30-day supply, regardless of tier. Out-of-network pharmacy: Insulin products are covered at a Tier 1, Tier 2 or Tier 3 copay and 40% coinsurance.	Not covered under medical plan benefits	In-network pharmacy: 20% coinsurance (up to $25 maximum per 30-day supply) for insulin products on the PDP drug list (formulary) Out-of-network pharmacy: 40% coinsurance for insulin products after annual out-of- network deductible is met	Not covered under medical plan benefits

*Benefits and covered brands of glucometers and test strips are subject to change.

Programs for a healthy life

Take care of yourself like you take care of Texas

The HealthSelect of Texas® and Consumer Directed HealthSelect℠ medical plans include a variety of wellness resources to help you care for yourself—because your well-being matters, too.

Buena Vida

Buena Vida can help you achieve your health goals with easy-to-use tools and well-being resources. You can also earn Buena Vida bucks for participating in healthy activities, such as taking the online health assessment and completing your annual preventive exam. Scan the QR code or visit **buenavidaers.com** for more information.

Online Buena Vida tools

You can subscribe to receive the Buena Vida Bulletin, where you'll get the latest updates on all things wellness.

Choose one of the following three options to subscribe:

- Visit the subscriber webpage at **ers.texas.gov** → **Contact ERS** → **Additional Resources** → **Subscribe**
- Text TXERS Wellness to 468311
- Scan the QR code

You can tune in to the Buena Vida podcast, hosted by ERS' coordinator for statewide well-being initiatives. The podcasts feature expert interviews, practical tips and real stories to inspire and guide you on your journey to better health and wellness. The Buena Vida podcast is available on most podcast platforms—including Apple podcasts, Google podcasts and Spotify. You can also visit the ERS Wellness Resources webpage at **ers.texas.gov** → **Wellness Resources** to access current and previous episodes.

Virtual Fitness

Join the Virtual Fitness Community and get moving with a variety of free Zoom classes led by passionate state employees who are also certified fitness instructors. Scan the QR code or visit **wellness.texas.gov/challenge.htm** for more information.

Wellness Events Calendar

ERS provides free educational webinars, in-person events, and Fitness & Nutrition Connect Communities designed to support the health and well-being of state employees and retirees. Explore topics like stress, sleep, nutrition and more—all in a supportive, engaging environment. Scan the QR code or visit **ers.texas.gov** → **Events** → **Wellness Calendar** for more information.

Hello Heart

Hello Heart focuses on cardiovascular health, aiming to prevent or decrease the development or advancement of heart disease and other cardiovascular conditions. Scan the QR code or visit **healthselectoftexas.com → Condition Management → Hello Heart** for more information.

Hinge Health

Hinge Health is an app-based exercise therapy program, led by physical therapists, that addresses joint, bone and muscle pain. Scan the QR code or visit **healthselectoftexas.com → Condition Management → Hinge Health** for more information.

Learn to Live

Learn to Live is an online, coach-supported program that can help you with mental health concerns, including depression, stress, anxiety and substance use. Scan the QR code or visit **healthselectoftexas.com → Condition Management → Learn to Live** for more information.

The Texas Employees Group Benefits Program offers two weight and lifestyle management programs for eligible HealthSelect of Texas participants, including those enrolled in Consumer Directed HealthSelect. Eligible individuals can participate in one program at a time.

Weight management resources:

Healthselect.bcbstx.com → Condition Management → Weight & Lifestyle Management Programs

Dental insurance

For an additional premium, you may enroll in one of the following dental plans.

You must enroll in a dental plan before you can add dependents, and your dependents must be enrolled in the same plan as you.

Go online

Find a list of providers for the State of Texas Dental Choice Plan℠ or DeltaCare® USA DMHO at **ERSdentalplans.com** or by calling Delta Dental, toll-free, at **(888) 818-7925 (TTY: 711)**, Monday – Friday, 8 a.m. – 7 p.m. CT.

State of Texas Dental Choice Plan℠

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

- Delta Dental PPO
- Delta Premier

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

Benefits are available in the United States. If you receive a covered service in Canada or Mexico, it will be processed as an out-of-network benefit. If you are traveling outside of the U.S., Canada or Mexico and need a covered service on an emergency basis, it will be processed as an out-of-network benefit, reimbursable in U.S. currency.

DeltaCare® USA dental health maintenance organization

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

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

"Smart" benefits

To keep costs low, active employees who sign up for GBP dental insurance will not get an ID card from the plan, and participating Delta dentists should not require them.

Instead, if you want a card, you can download a digital card to your smartphone through the Delta Dental app. If you don't have a smartphone, you can download and print your information from **ERSdentalplans.com** or call Delta Dental toll-free at **(888) 818-7925 (TTY: 711)** and they will mail a paper copy to you.

Note: Covered dependents cannot access the app, and their names are not 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.

Dental plans comparison chart

This chart is a summary of benefits in the two dental insurance plans. It shows your share of costs in each plan for commonly used services. See plan booklets at **ERSdentalplans.com** 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 dentist**	**Out-of-network dentist**	You must select a primary care dentist (PCD). NOTE: Not all in-network dentists accept new patients. Dentists are not required to stay on the plan for the entire year.
Deductibles	**Preventive:** Individual-$0; Family-$0 **Combined Basic/Major:** Individual-$50; Family-$150 **Orthodontic services:** no deductible In State of Texas Dental Choice, deductibles are based on the calendar year and reset on January 1.	**Preventive:** Individual-$50; Family-$150 **Combined Basic/Major:** Individual-$100; Family-$300 **Orthodontic services:** no deductible	None
Copays / coinsurance	**Preventive and Diagnostic Services:** none **Basic Services:** 10% coinsurance after meeting the basic services deductible **Major Services:** 50% coinsurance after meeting the major services deductible There is no charge for anything over the allowed amount. After reaching the maximum calendar year benefit, the participant pays 60% until January 1.	**Preventive and Diagnostic Services:** 10% coinsurance after meeting the preventive and diagnostic deductible **Basic Services:** 30% coinsurance after meeting the basic services deductible **Major Services:** 60% coinsurance after meeting the major services deductible Participants may be required to pay the difference between the allowed amount and billed charges. Once the maximum calendar year benefit is reached, the participant pays 100% until January 1.	**Primary care dentist (PCD):** Copays vary according to service and are listed in the “Schedule of Dental Benefits” booklet. **Specialty dentistry:** 75% of the dentist’s usual and customary fee when specialty care is coordinated by the PCD (DHMO pays nothing)
Maximum calendar year benefits	$2,000 per covered individual (includes orthodontic extractions) plus 40% after maximum calendar year benefit is met	Does not apply to orthodontic services provided by out-of-network dentists (plan pays $0)	Unlimited
Maximum lifetime benefit	$2,000 per covered individual for orthodontic services	$2,000 per covered individual for orthodontic services	Unlimited
Average cost of cleaning / oral exams	Up to two cleaning/oral exams per calendar year allowed	10% of the allowed amount after deductible is met Up to two cleaning/oral exams per calendar year allowed	Vary according to service and are listed in the “Schedule of Dental Benefits” booklet Up to two cleaning/oral exams per calendar year allowed
Orthodontic coverage	50% of the allowed amount	50% of the allowed amount Participants may be required to pay the difference between the allowed amount and billed charges.	**Orthodontic services performed by a general dentist listed in the directory with a “0” treatment code:** child–$1,800; adult–$2,100 **Orthodontic services performed by a specialist:** 75% of the usual fee (DHMO pays nothing)

Check the Discount Purchase Program for dental discounts

The Discount Purchase Program, administered by Beneplace, sometimes offers dental discount programs and discounted dental services. You can view them at **discountprogramers.com**. (To access discounts, you will need to register using your email address.)

Vision insurance

Vision benefits are an easy way for you and your dependents to maintain healthy vision and eyes. With State of Texas Vision℠, you can save money on eye exams and eyewear for yourself and your family with a small monthly premium and low copays. EyeMed Vision Care, LLC (EyeMed) is the administrator of State of Texas Vision.

State of Texas Vision covers an eye exam and includes an allowance for eyeglass frames or contact lenses once every plan year, as well as discounts for LASIK. The plan gives you an annual $200 retail allowance to use toward either contact lenses OR eyeglass frames in the same plan year. For example, if you use your $200 allowance to purchase contact lenses, you won't have an allowance for eyeglass frames for the remainder of the plan year.

Vision coverage comparison chart, in-network vs. out-of-network services

Vision plan participants have access to EyeMed's INSIGHT network which includes independent, national and regional retailers and online providers. All allowances are retail; you're responsible for any charges in excess of the retail allowances, minus available discounts. Discounts are not funded benefits and may vary or change based on provider or manufacturer. Search the EyeMed provider network at **member.eyemedvisioncare.com/stateoftexasvision**.

Vision Care Services	In-Network Member Cost	Out-of-Network Member Reimbursement
Exam Services		
Exam	$15 copay[1]	Up to $40 after $15 copay
Contact Lens Fit and Follow-Up[2]		
Fit and Follow-up – Standard	$25 copay[1]	Up to $100
Fit and Follow-up – Premium	$35 copay[1]	Up to $100
Frame		
Frame	$200 retail allowance; 20% off amount over $200	Up to $75
Lenses		
Single Vision	$10 copay[1]	Up to $30
Bifocal	$15 copay[1]	Up to $45
Trifocal	$20 copay[1]	Up to $60
Progressive – Standard[3]	$70 copay plus bifocal $15[1]	Up to $45
Lens Options		
Polycarbonate - Standard	$40 copay[1]	Not covered
Scratch Coating - Standard Plastic	$10 copay[1]	Not covered
Tint - Solid and/or Gradient	$10 copay[1]	Not covered
UV Treatment	$10 copay[1]	Not covered
Anti-Reflective Coating - Standard	$40 copay[1]	Not covered
Contact Lenses		
Contacts - Elective	$200 allowance	Up to $200
Contacts - Medically Necessary	$0 copay	Up to $210
Other		
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call **(800) 988-4221**	Not covered
Retinal Imaging	You are responsible for 100% of the cost, which is up to $39 for EyeMed customers.	Not covered

[1] Covered in full after copay is met.

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

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

Optional life insurance

Optional Term Life Insurance

Your GBP health coverage includes $5,000 of Basic Term Life Insurance and $5,000 of Accidental Death and Dismemberment (AD&D) coverage at no cost to you. You can purchase additional life insurance coverage in increments based on your annual salary. Both Basic and Optional Term Life Insurance are insured by Securian.

If you choose **Optional Term Life Election 1 or 2** (one or two times your annual salary) within 30 days after your start date (not including your start date), you will not have to provide evidence of insurability (EOI). If you do not sign up as a new employee, you can apply when you have a qualifying life event or during Summer Enrollment, but you will have to provide EOI and coverage is not guaranteed.

You can apply for **Optional Term Life Election 3 or 4** (three or four times your annual salary) up to $400,000. You will have to provide EOI, a process that requires you to provide information about your health. Coverage is not guaranteed; you may not be approved for benefits based on the information included in your EOI.

Each Optional Term Life election provides an equal amount of additional AD&D coverage.

Securian's website for GBP members can help you decide how much life insurance coverage you might need: **securian.com/content/securian/en/insights-tools/life-insurance-needs-calculator**.

Premiums and coverage amounts for each plan year (Sept. 1 – Aug. 31) will be based on the salary reported to ERS on Sept. 1 of that plan year. Your monthly premiums for Optional Term Life Insurance will depend on your age, salary and level of coverage each plan year. To calculate your premium, see page 36 of this guide.

Like with most group term life policies, premiums for the GBP's Optional Term Life Insurance increase as the policyholder ages. Age-based coverage reductions start at age 70. For more information, visit the Securian website to review a plan overview and learn more about coverage options for yourself and your dependents.

Dependent Term Life Insurance

For an additional premium, you can enroll your eligible dependents in term life insurance. The plan includes $5,000 term life with $5,000 AD&D for each covered dependent, for a monthly premium of just a few dollars. You will get the life insurance benefit if your covered dependents die. You will get the AD&D benefit if they die or suffer certain injuries in an accident. One monthly premium covers all your eligible dependents, but all eligible dependents must be named under the coverage.

If you do not sign up as a new employee, you can apply for this insurance when you have a qualifying life event or during Summer Enrollment, but you will have to supply EOI and coverage is not guaranteed. You do not need to supply EOI for Dependent Term Life Insurance if you add a new dependent, such as a new spouse or child, within 30 days of getting married or within 30 days of the child's birth or placement, not including the day of the event.

Within 30 days of your start date: No questions

If you want additional life insurance coverage and disability insurance, your first 30 days of employment (not including your start date) is the best time to sign up because you will not have to provide EOI for Optional Term Life Election 1 or 2, or for short-term or long-term disability insurance. EOI is an application process during which you must provide information about your or your dependents' health. Don't miss this 30-day window of opportunity! If you wait, you run the risk of not qualifying for these benefits based on EOI results.

Understanding term life insurance

Term life insurance is temporary. That is, you're covered only as long as you're eligible as an employee or retiree of a state agency or higher education institution, and paying the monthly premium. It is less expensive than whole life insurance and provides a way to bulk up your coverage when you're bringing home a paycheck. Your working years tend to be when your family's expenses are highest and, therefore, when they need the most financial protection against unexpected loss of life and income.

The temporary nature of the benefit is part of what makes it so cost-effective and flexible. It's similar in function to your homeowner's and car insurance in that you pay only what it costs to insure yourself at the time you're paying premiums and for the amount of coverage you have.

You may decide to increase coverage when you're growing a family and decrease (or even drop) it later, when you have fewer financial obligations.

Designate your beneficiaries

Although you aren't required to do so in your first month, it's a good idea to designate your beneficiaries for your life insurance policy and Texa$aver account as soon as you can.

You can find instructions on how to designate your beneficiaries for each at **ers.texas.gov → Active Employees → Life Changes → Account Beneficiaries**.

Voluntary AD&D insurance

Voluntary Accidental Death and Dismemberment (AD&D) Insurance coverage can provide additional financial support if there is an accidental death or injury of a certain type. You can choose insurance in increments of $5,000, starting at $10,000 up to $200,000. You will not have to provide EOI for AD&D Insurance. Securian insures AD&D insurance benefits.

You can sign up for coverage for yourself only, or for yourself and your eligible dependents.

Coverage includes the following:

- If you die as the direct result of an accidental bodily injury, your beneficiaries will receive the full amount of your coverage.
- Enrolled family members are covered at partial benefit levels. Your spouse is covered at 50% of your enrolled amount. Eligible children are covered at a lower percentage, which is reduced if your spouse is alive at the time of your child's death.
- If you have an accident and suffer any of the covered injuries, such as loss of a hand, a foot, or sight in one or both eyes, you will receive a percentage of the full amount of your coverage.
- If an eligible family member loses a hand, a foot, or sight of one or both eyes in an accident, you receive a percentage of the benefit if you have coverage for that family member.

You can update your beneficiaries at any time. Go to **ers.texas.gov → Active Employees → Life Changes → Account Beneficiaries** for step-by-step instructions.

Disability insurance

Could you afford to go months or even weeks without a paycheck? The Texas Income Protection Plan℠ (TIPP) provides you with money to help pay your bills if an illness, injury or other health-related condition, including pregnancy, makes it impossible for you to work.

- **Short-term disability insurance** provides a maximum benefit of 66% of your monthly salary, with a cap of $6,600 per month for those making more than $10,000 monthly, a maximum of 166 days. For example, if your monthly salary is $4,800, the highest amount you'll get for short-term disability is $3,168 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 $4,800 per month, your monthly long-term disability payment would be $2,880. 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.

Pre-existing conditions are subject to certain exclusions.

You must use all of your sick leave (including extended sick leave, donated sick leave and sick leave pool) or complete a waiting period of 14 consecutive days for short-term, 180 days for long-term, whichever option is longest, before disability payments will be paid. You are not required to use your vacation time.

If you are eligible for workers'compensation payments and/or State of Texas disability retirement, your long-term disability payments may be reduced. The minimum benefit is 10% of your monthly salary.

TIPP coverage is not available for family members.

Please review the plan documents, including the user's guide, at **texasincomeprotectionplan.com**, before applying for TIPP disability insurance.

TIPP coverage overview

	Short-term disability coverage	Long-term disability coverage
Monthly benefits	Provides a maximum benefit of 66% of your monthly salary, up to a $6,600 benefit each month if your monthly salary is more than $10,000. **Example:** Your monthly salary is $4,000, The maximum you will be eligible for is $2,640 per month (66% of your salary).	Provides a maximum of 60% of your monthly salary, up to a $6,000 benefit each month if your monthly salary is more than $10,000. **Example:** Your monthly salary is $4,000. The maximum you will be eligible for is $2,400 per month (60% of your salary).
Potential benefit reduction	Benefits are reduced if you get other disability payments (Social Security Disability Insurance, Workers' Compensation payments, ERS disability retirement benefits, Teacher Retirement System of Texas disability retirement benefits and/or other disability payments). The minimum benefit is 10% of your monthly salary.	Benefits are reduced if you get other disability payments (Social Security Disability Insurance, Workers' Compensation payments, ERS disability retirement benefits, Teacher Retirement System of Texas disability retirement benefits and/or other disability payments). The minimum benefit is 10% of your monthly salary.
When do benefits start?	After a waiting period of 14 consecutive days or after you've used all your sick leave (whichever is longer); any sick leave must be used during the 14-day waiting period.	After a waiting period of 180 consecutive days or after you've used all your sick leave (whichever is longer); any sick leave must be used during the 180-day waiting period.
How long are benefits paid?	Up to 166 days after the completion of your waiting period, but may vary depending on sick leave exhaustion.	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:** For mental diseases and disorders, the maximum benefit period for disability is two years. If you become disabled at age 69 or older, benefits are payable for up to 12 months.

TIPP disability insurance coverage is administered by Alight, Inc.

If you do not sign up as a new employee, you can apply for this insurance when you have a qualifying life event or during Summer Enrollment, but you will have to supply EOI and coverage is not guaranteed. EOI for short-term and long-term disability coverage is managed by Brown and Brown.

Thomas Barker-White

Statewide intake supervisor

GBP participant Thomas Barker-White has worked for the Texas Department of Family and Protective Services (DFPS), including as a statewide intake supervisor overseeing a staff of nine.

Barker-White and his wife, Lutishia, a former state employee, value their ERS-administered health and retirement benefits.

They set aside money for retirement through Texa$aver to prepare for their future. They believe it is a good benefit for employees who don't trust their own judgment with investments.

But in 2011, the most important benefit became short-term and long-term disability insurance.

In 2011, Lutishia became disabled due to arthritis and related injuries. Her disability insurance payments made up for a portion of the income she lost when she could no longer work.

As a result, the couple was able to manage their finances without any substantial changes.

Having both short-term and long-term disability insurance made a huge difference by providing the financial support the couple needed when one of them could no longer work, says Barker-White.

"I know people who work in the private sector who do not have access to disability insurance through their employer.

They can buy it on their own, but the premium is not as reasonable as what we have as state employees."

Barker-White appreciates that the state covers the full cost of the employee's health insurance premium. It's another valuable benefit that makes working for the state attractive, he says.

"Having good insurance coverage is so important. You may never need it (and I hope you don't), but if you do, you are probably REALLY going to need it. Life can come at you quick, so it's best to cover all your bases."

TexFlex℠

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

Before you enroll, you may want to use the tools in the Program Resources section of the TexFlex website at **texflexers.com** to figure out how much to contribute to each account.

Summer Enrollment is the only time you can change the amount you contribute to your TexFlex FSA(s), unless you have a qualifying life event during the plan year. Once you're enrolled, if you do not make a change during Summer Enrollment, you will continue enrollment and your annual contribution will stay the same in the next plan year.

Save on taxes

The benefit of TexFlex accounts is the ability to save on taxes. Contributions to an FSA are deducted before you pay income taxes, lowering your taxable income. The federal Internal Revenue Service (IRS) regulates FSAs. The IRS says what you can spend FSA funds on and sets deadlines for when you must use the money in your FSAs. If you don't spend your FSA money by those deadlines, you could lose at least some of that money. If you are considering enrolling, you should use the contribution worksheet or calculator at **texflexers.com** to help you decide how much you should to contribute based on your planned expenses.

Active employees may be eligible to enroll in more than one TexFlex account at a time. See the chart on page 31 for rules that apply to each type of account.

If you enroll in Consumer Directed HealthSelect, you cannot enroll in a health care FSA. But you can enroll in a limited-purpose FSA. You can use the limited-purpose FSA for eligible out-of-pocket dental and vision expenses only. General health care expenses that are eligible under a health care FSA–such as doctor visits and prescription medicines–are NOT eligible under a limited-purpose FSA.

Visit **texflexers.com → Program Resources** for more information for more information.

Leftover TexFlex dollars?

Health care or limited-purpose FSA: At the end of Plan Year 2026 (Sept. 1, 2025 – Aug. 31, 2026), you can carry over unused health care or limited-purpose funds between $25 and $660 to Plan Year 2027. You will lose any funds over $660 if you do not spend them by the end of the plan year on Aug. 31.

Dependent care FSA: You cannot carry over any funds in a dependent care FSA, but you have extra time to spend unused funds, called the grace period. The grace period allows you 2½ more months after the plan year ends on Aug. 31 (through Nov. 15) to use any leftover money in that account. You will lose any funds from the previous plan year that you don't use by Nov. 15.

See the chart on page 31 for more details on carryovers and the grace period. Forfeited money goes into the overall TexFlex fund to help pay administrative costs of the program.

How to pay with TexFlex

After you enroll in a TexFlex health care or limited-purpose FSA, you will get a debit card in the mail that you can use to pay eligible expenses, such as a prescription or a dentist visit. If you have a TexFlex dependent care account, you must submit a claim for reimbursement after the eligible services have been provided, and you must have the funds in your account. You cannot use a TexFlex debit card to pay dependent care expenses.

For the health care FSA or limited-purpose FSA, you can choose not to use the debit card and instead submit a claim for reimbursement online, or by mail or fax.

If you submit a claim for reimbursement online or by mail or fax, TexFlex will mail a check to you. For quicker reimbursement, set up a direct deposit for funds to be deposited directly into your bank account within a few days.

Keep your receipts

Because TexFlex accounts are tax-free, the IRS requires all purchases with TexFlex funds to be validated.

Inspira Financial, the TexFlex plan administrator, may ask you to submit proof that you used your TexFlex funds to pay for eligible expenses. Please remember to **SAVE YOUR RECEIPTS**, regardless of how you pay. If you cannot provide a receipt for an eligible purchase with your TexFlex debit card, Inspira might ask you to reimburse your account for the funds. Your debit card will be suspended if you do not submit documentation for purchases made with your debit card that require validation.

Flexible spending accounts in Plan Year 2026

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 **TexFlexERS.com**	• Copays, coinsurance and other out-of-pocket medically necessary charges not covered by insurance or reimbursed by another source • Prescription drug deductible and copays • Over-the-counter medicine	• Vision and dental expenses not covered by insurance or reimbursed by another source	• Day care, after-school care and summer day camp for dependent children under age 13 • Adult day care programs for qualifying individuals
Maximum contribution	$3,300	$3,300	$5,000 per household*
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	Up to $660 in carryover is allowed from Plan Year 2026 (ending Aug. 31, 2026) to Plan Year 2027 (starting Sept. 1, 2026). Unspent Plan Year 2026 funds above $660 will be forfeited.		There is a 2 ½-month grace period from Sept. 1 through Nov. 15, 2026. Any Plan Year 2026 funds not spent by Nov. 15, 2026 will be forfeited.
Runout period	Submit claims for eligible expenses you paid between Sept. 1, 2025 and Aug. 31, 2026 by Dec. 31, 2026.		Submit claims for eligible expenses you paid between Sept. 1, 2025 and Nov. 15, 2025 by Dec. 31, 2025.

*If you are a highly compensated individual based on IRS definitions, the maximum amount you can elect is lowered to $1,250 each year.

Serena Lopez

For much of her career with the state, GBP participant Serena Lopez helped many active employees and retirees understand which benefits options are right for them. For this mother of three, TexFlex makes sense.

“TexFlex allows me to put aside money tax-free for medical expenses and lowers my taxable income.”

“My kids seem to get sick like clockwork in November, just when I’m starting to make my holiday shopping list. That’s when I’m glad I have my TexFlex health care flexible spending account to pay for doctor visits and medicine. By setting aside a certain amount from my paycheck each month, I know the money will be there when I need it.”

Most of your employee benefits—health, dental, life, vision, disability and flexible spending accounts—are offered through ERS. Each retirement system has specific rules and the rules for your retirement depend on your employer. Contact your system for details.

Employer	Retirement system or plan	Contact information
Community Supervision and Corrections Departments (CSCDs)	Texas County and District Retirement System (TCDRS)	**(800) 823-7782** **tcdrs.org**
Higher education institutions	Teacher Retirement System (TRS) or Optional Retirement Program (ORP) through the Texas Higher Education Coordinating Board	**TRS: (800) 223-8778,** **trs.texas.gov** **or (512) 427-6101** **highered.texas.gov**
Texas County & District Retirement System	TCDRS	**(800) 823-7782** **tcdrs.org**
Texas Municipal Retirement System (TMRS)	TMRS	**(800) 924-8677** **tmrs.org**
Teacher Retirement System of Texas	TRS	**(800) 223-8778** **trs.texas.gov**
Windham School District	TRS	**(800) 223-8778** **trs.texas.gov**

Health insurance in retirement

Texas Employees Group Benefits Program (GBP) retiree insurance is currently available to retirees with at least 10 years of eligible service credit at a state agency or higher education institution participating in the GBP. **Please note:** Independent school districts (with the exception of Windham School District), the University of Texas System and the Texas A&M University System do not participate in the GBP, so service with those employers does not count as eligible service credit toward the required 10 years. A retiree who meets this requirement is eligible for GBP retiree health insurance benefits at age 65 or after meeting the Rule of 80. You meet the Rule of 80 when the sum of your age and service credit—in both months and years—equal or exceed 80. For retirees eligible for GBP health insurance, the amount the state pays toward their monthly premium varies depending on their years of service. For more information on health insurance in retirement, go to **ers.texas.gov → Retirees → Health Benefits**.

As with all GBP benefits, health insurance for retirees is subject to change without notice. The Texas Legislature sets the level of funding for such benefits and has no continuing obligation to provide those benefits beyond each fiscal year.

Texa$aver 457 Plan

Save more for retirement with a Texa$aver 457 account

TEXA$AVER 457 Plan

Texa$aver is a voluntary deferred compensation program that can help you save for retirement. A Texa$aver 457 account offers the chance to save through a variety of investment opportunities at lower-than-average fees.

If you work for a higher education institution, you may be eligible to participate in a Texa$aver 457. Your pension may not provide automatic cost-of-living increases, so a Texa$aver account (or other personal retirement savings) could help you live more comfortably when you're no longer working.

Contact your benefits coordinator or HR department to find out if your higher education institution participates.

ERS manages the Texa$aver program, along with third- party administrator Empower.

Depending on your age, a $68 monthly contribution in a Texa$aver account until age 65 can grow into a higher monthly payment to yourself in retirement.

Age at which you start contributing $68 monthly	Gross monthly payment from age 65 to 85, assuming investments yield 6% rate of return
Age 30 ($28,560 total investment)	**$694** ($96,880 total savings + investment earnings)
Age 40 ($20,400 total investment)	**$338** ($47,124 total savings + investment earnings)
Age 50 ($12,240 total investment)	**$142** ($19,776 total savings + investment earnings)
Age 60 ($4,080 total investment)	**$34** ($4,744 total savings + investment earnings)

As an illustration only, this hypothetical scenario shows possible retirement income. Please note:

- It is not a projection or prediction of future investment results, nor is it intended as financial planning or investment advice.
- It assumes a 6% annual rate of return in both the accumulation and withdrawal phases.
- It assumes reinvestment of earnings and a payee lifespan of 20 years in retirement.
- Rates of return may vary.
- Payments (also known as withdrawals or distributions) from a tax-deferred retirement plan may be taxable as ordinary income.
- The scenario does not take into account income taxes on payments from a 401(k) or 457 account, or any associated charges, expenses or fees. The hypothetical income shown would be reduced if these fees and/or taxes were deducted.

Contact your benefits coordinator or HR representative to find out if your higher education institution participates.

Call to request a free Texa$aver welcome packet, or for more information on getting started.

Learn more:

- **www.texasaver.com**
- (800) 634-5091

Texa$aver administrative fees

Administrative fees for new Texa$aver accounts are waived for six months. At the end of the waiver period, a monthly fee will be deducted from your account. Fees are charged at $1.50 per participant, per month, regardless of the account balance.

Rolling over funds from other retirement accounts to Texa$aver

Do you have retirement savings accounts from other jobs? You can transfer—or "roll over"—money from a qualified prior eligible employer's 401(k), 401(a), 403(b) or governmental 457 plan into your Texa$aver 457 account. You can also roll over money from an eligible individual retirement account (IRA). Texa$aver 457 plans accept Roth rollovers from other qualified plans as well, but you cannot roll over Roth IRAs to Texa$aver.

You should discuss rolling money from one account to another with your financial advisor/planner, considering any potential fees and/or limitation of investment options.

Texa$aver is not available to employees of CSCD, TCDRS, TMRS or Windham School District.

Plan Year 2026 Rates

Monthly Premiums (Sept. 1, 2025 – Aug. 31, 2026)

Full-time Employees and Retirees Not Eligible for Medicare

	Premium*	State Pays	You Pay
HealthSelect of Texas®			
You Only	$ 674.62	$ 674.62	$ 0.00
You + Spouse	1,447.90	1,061.26	386.64
You + Children	1,192.38	933.50	258.88
You + Family	1,965.66	1,320.14	645.52
Consumer Directed HealthSelect℠ **			
You Only	$ 674.62	$ 674.62	$ 0.00
You + Spouse	1,409.22	1,061.26	347.96
You + Children	1,166.50	933.50	233.00
You + Family	1,901.10	1,320.14	580.96

*Includes applicable premium for Basic Term Life Insurance

**The "State Pays" amount includes a monthly contribution to the member's Optum Bank health savings account (HSA). Please see the Consumer Directed HealthSelect HSA Contribution table below.

Part-time Employees and Retirees Not Eligible for Medicare, Graduate Students/ Teaching Assistants, Post-doctoral and Adjunct Faculty†

	Premium*	State Pays	You Pay
HealthSelect of Texas®			
You Only	$ 674.62	$ 337.31	$ 337.31
You + Spouse	1,447.90	530.63	917.27
You + Children	1,192.38	466.75	725.63
You + Family	1,965.66	660.07	1,305.59
Consumer Directed HealthSelect℠ **			
You Only	$ 674.62	$ 337.31	$ 337.31
You + Spouse	1,409.22	530.63	878.59
You + Children	1,166.50	466.75	699.75
You + Family	1,901.10	660.07	1,241.03

*Includes applicable premium for Basic Term Life Insurance

**The "State Pays" amount includes a monthly contribution to the member's Optum Bank health savings account (HSA). Please see the Consumer Directed HealthSelect HSA Contribution table below.

†The state does not contribute to the cost of health insurance for adjunct faculty.

Consumer Directed HealthSelect℠ Health Savings Account (HSA) Contribution

	State Pays
You Only	$ 45 monthly ($540 annually)
You + Spouse	90 monthly ($1,080 annually)
You + Children	90 monthly ($1,080 annually)
You + Family	90 monthly ($1,080 annually)

An HSA is a tax-free savings account for qualified health expenses.

You can receive the "State Pays" HSA contribution if you are:

- enrolled in Consumer Directed HealthSelect,
- eligible for a portion of your health premium to be paid by the state and
- not eligible for Medicare.

Dental Insurance

DeltaCare® USA DHMO	Employee/ Retiree	COBRA	COBRA Disability	Surviving Dependents	
You Only	$ 9.59	$ 9.78	$ 14.39	Spouse Only	$ 9.59
You + Spouse	19.18	19.56	28.77	Spouse + Children	23.02
You + Children	23.02	23.48	34.53	Children Only	13.43
You + Family	32.59	33.24	48.89		

State of Texas Dental Choice Plan℠	Employee/ Retiree	COBRA	COBRA Disability	Surviving Dependents	
You Only	$ 31.03	$ 31.65	$ 46.55	Spouse Only	$ 31.03
You + Spouse	62.06	63.30	93.09	Spouse + Children	74.47
You + Children	74.47	75.96	111.71	Children Only	43.44
You + Family	105.50	107.61	158.25		

Vision Insurance

State of Texas Vision℠	Employee/ Retiree	COBRA	COBRA Disability	Surviving Dependents	
You Only	$ 5.07	$ 5.17	$ 7.61	Spouse Only	$ 5.07
You + Spouse	10.14	10.34	15.21	Spouse + Children	10.90
You + Children	10.90	11.12	16.35	Children Only	5.83
You + Family	15.97	16.29	23.96		

Tobacco-user Premium

If you and/or a family member enrolled in health insurance is certified as a tobacco user, you will pay an additional tobacco-user premium of $30, $60 or $90 each month, depending on how many tobacco users or uncertified family members you cover.

Tobacco Users of Any Age and Adults Age 18 and Over Who Fail to Certify	Monthly Tobacco-user Premium
Member or Spouse or Children* Only	$30
Member + Spouse or Member + Children* or Spouse + Children*	$60
Family (Member + Spouse + Children*)	$90

*The charge for a child is the same regardless of how many children in the household use tobacco or how many covered children age 18 or over are not certified.

The plans on this page are not available to surviving dependents, or those enrolled through COBRA and COBRA Disability.

Optional Term Life Insurance

Optional Term Life Insurance				
Age	**Election 1 Annual Salary x 1**	**Election 2 Annual Salary x 2**	**Election 3* Annual Salary x 3**	**Election 4*† Annual Salary x 4**
	Monthly Rate per $1,000 of Annual Salary			
Under 25	$ 0.05	$ 0.10	$ 0.15	$ 0.20
25 - 29	0.05	0.10	0.15	0.20
30 - 34	0.06	0.12	0.18	0.24
35 - 39	0.06	0.12	0.18	0.24
40 - 44	0.08	0.16	0.24	0.32
45 - 49	0.13	0.26	0.39	0.52
50 - 54	0.20	0.40	0.60	0.80
55 - 59	0.35	0.70	1.05	1.40
60 - 64	0.60	1.20	1.80	2.40
65 - 69	0.98	1.96	2.94	3.92
70 - 74	1.56	3.12	4.68	6.24
75 - 79	2.55	5.10	7.65	10.20
80 - 84	4.15	8.30	12.45	16.60
85 - 89	7.18	14.36	21.54	28.72
90+	11.18	22.36	33.54	44.72

After the first 30 days of employment (not including your start date), Elections 1 and 2 require approval through evidence of insurability (EOI).

Elections 3 and 4 always require EOI approval.

Beginning at age 70, Optional Term Life coverage is reduced to a percentage of your annual salary as follows:

Age 70-74	65%
Age 75-79	40%
Age 80-84	25%
Age 85-89	15%
Age 90+	10%

Retiree Fixed Optional Life Insurance ($10,000 policy)
$24.80 per month for $10,000

Dependent Term Life Insurance	
Employee: $1.45 per month for $5,000 (includes $5,000 AD&D coverage)	**Retiree:** $3.23 per month for $2,500

†Optional Term Life Insurance is limited to a maximum of $400,000 or four times your annual salary, whichever is less.

Voluntary Accidental Death & Dismemberment Insurance (AD&D)*

You may enroll in AD&D coverage according to the following table:

Age	Minimum Coverage	Maximum Coverage	Minimum Increments
Under 70	$ 10,000	$ 200,000	$ 5,000
70-74	6,500	130,000	3,250
75-79	4,000	80,000	2,000
80-84	2,500	50,000	1,250
85-89	1,500	30,000	750
90+	1,000	20,000	500

You Only
$0.02 per $1,000 of coverage

You + Family
$0.04 per $1,000 of coverage

Texas Income Protection Plan℠ (TIPP)*

Short-term Disability (same as PY25)	**Long-term Disability** (decrease from PY25)
$0.24 per $100 of monthly salary	$0.63 per $100 of monthly salary

*Optional Term Life Insurance at Elections 3 and 4, AD&D, and short-term and long-term disability insurance are not available to retirees.

Learn more about your State of Texas benefits

ERS website: ers.texas.gov

The ERS website has information and tools to help you make the best use of your benefits. Use the Search function to find detailed information on ERS insurance, retirement and related benefits.

Monthly *Money MattERS*

This e-newsletter promotes financial literacy among active employees at state agencies and some higher education institutions.

Money Talks is a monthly podcast companion to the *Money MattERS* newsletter.

You can sign up for the newsletter and podcast at **ers.texas.gov → Subscribe to Topic Alerts**.

Monthly *News About Your Benefits*

This e-newsletter provides information on available programs, wellness, health plans and other benefits. You can sign up to get this every month and other news by email at **ers.texas.gov → Subscribe to Topic Alerts**.

Your Texa$aver quarterly statement

You will get a statement each quarter from Texa$aver, currently administered by Empower, detailing your Texa$aver account balance and investment choices.

Your annual Personal Benefits Enrollment Statement

Before Summer Enrollment every year, ERS will send you a personalized statement listing your current coverage, costs and choices for the next plan year. You will have the opportunity to make changes each year during Summer Enrollment. You should review this statement even if you do not think you will make any changes.

Your HR department

See your benefits coordinator or human resources representative for help signing up for and understanding insurance benefits.

Presentations and events

ERS holds seminars, webinars, fairs and other events throughout the year.

- **Summer Enrollment fairs and webinars**: Every year during Summer Enrollment, ERS and our GBP program administrators offer webinars and travel around the state to inform employees and pre-Medicare retirees about any benefits changes for the upcoming plan year. We also share ways you can get the most from your GBP benefits.
- **Ready, Set, Retire!**: Conducted throughout the state and as a webinar, this is a free 90-minute seminar on ERS retirement and the Texa$aver 457 Program.
- **Medicare Preparation**: Conducted throughout the state and as a webinar, this presentation helps those approaching Medicare eligibility understand enrollment and how Medicare works with state health insurance.
- **Health and wellness**: ERS hosts wellness events and webinars that provide you with the tools you need to take charge of your health.

To see a list of upcoming events or to register, go to **ers.texas.gov → Event Calendars**.

Contacting ERS after hours

For 24/7 access to automated information on your insurance, call toll free **(877) 275-4377**.

Designate your beneficiaries

It's not required within your first month, but it's a good idea to designate your beneficiaries for life insurance and Texa$aver account as soon as you can.

- For life insurance, log in to your ERS OnLine account. You will need to provide your beneficiaries' Social Security numbers, dates of birth and mailing addresses.

You can find instructions on how to designate your beneficiaries for each type of account including your Texa$aver account(s), at **ers.texas.gov → Contact ERS → Additional Resources → ERS OnLine → Update Your Beneficiaries**.

Tips for saving money in HealthSelect plans

Making the best use of your HealthSelect benefits might require a little extra effort. Learn about your coverage, confirm that all providers are in the network, get referrals when needed, and opt for lower-cost drugs and providers when appropriate. Taking those extra steps will help you save money—sometimes a lot of money—and avoid surprise bills, while getting high-quality care.

Get care from an in-network provider.

In-network providers have a contract to provide care at a lower rate negotiated by Blue Cross and Blue Shield of Texas (BCBSTX), the third-party administrator of the HealthSelect of Texas plans. So, they typically cost you less than an out-of-network provider. BCBSTX also makes sure they have the credentials to provide appropriate, high-quality care.

Out-of-network providers do not have a contract with BCBSTX to accept the lower amount. If you see an out-of-network provider, you may be responsible for the difference between what the plan usually pays (the allowable amount) and what the provider charges, as well as any applicable out-of-network deductibles, coinsurance and copays.

Call BCBSTX or visit **healthselectoftexas.com** and click on “Find a Doctor, Lab, or Hospital” to find in-network providers in your health plan. Call Express Scripts or visit **healthselectrx.com** to find in-network pharmacies.

Consider a Virtual Visit when appropriate—for both medical and mental health.

Virtual Visits through Doctor on Demand® and MDLIVE® are covered at 100% if you are enrolled in HealthSelect of Texas, HealthSelect℠ Out-of-State or HealthSelect℠ Secondary. If you are enrolled in Consumer Directed HealthSelect, you must meet your annual deductible. After you meet your deductible, you will pay 20% coinsurance. Virtual Visits are more convenient— letting you consult with a Board-certified doctor or mental health professional via smartphone, tablet or computer from home or anywhere you have internet access. Learn more at **healthselect.bcbstx.com → Medical Plans and Benefits → Virtual Visits**.

In HealthSelect of Texas, choose a PCP and get referrals when needed.

If you are in HealthSelect of Texas, you need to designate a primary care provider (PCP) on file with BCBSTX and make sure you have your PCP’s referral on file with BCBSTX before you see most specialists. Otherwise, your specialist visit will be considered out of network, even if the specialist is in the HealthSelect network. You can verify that a referral is in place by calling BCBSTX or logging in to your Blue Access for Members℠ account at **healthselectoftexas.com**. (Some specialist visits don’t require referrals. Find out which on page 10 of this guide, on the HealthSelect website or by calling BCBSTX.)

Use the Provider Finder tool.

You can estimate health costs and compare costs for different providers. Log in to your Blue Access for Members account and click the "Doctors & Hospitals" tab at the top of the screen. Select "Find a Doctor or Hospital" and use “Provider Finder” to estimate health costs with different in-network providers. With Provider Finder, you’ll be able to:

- compare costs for in-network providers and procedures,
- compare quality ratings for those providers,
- estimate out-of-pocket costs,
- consider your treatment options and
- save money and make the best use of your health care benefits.

Compare costs before you go.

You can find the lowest-cost in-network providers for a number of procedures and services in your area:

1. Log in to your Blue Access for Members account at **healthselectoftexas.com**.
2. Scroll to the bottom of the page and click on the Cost Estimator.
3. Input the requested information to compare the costs of care with different in-network providers.

You can also save money on prescriptions by logging in to your Express Scripts account at **healthselectRx.com** and using the Drug Pricing Tool to compare a drug’s cost across in-network pharmacies, or learn what you could save by using the mail-order pharmacy.

Participate in HealthSelectShoppERS℠.

You may earn rewards when you choose to save with HealthSelectShoppERS on certain medical services. HealthSelectShoppERS is a health care shopping and savings program available to benefits-eligible active employees enrolled in HealthSelect of Texas®, HealthSelect℠ Out-of-State or Consumer Directed HealthSelect℠. Retirees, Medicare-primary participants, COBRA members and HealthSelect℠ Secondary participants are not eligible for the HealthSelectShoppERS program.

HealthSelectShoppERS can help you:

- compare costs for many health care procedures,
- estimate out-of-pocket costs,
- earn rewards for certain medical services and procedures by shopping for care and choosing lower cost providers, and
- save money and get the most value from your health care benefits.

How does the HealthSelectShoppERS program work?

After your primary care provider (PCP) or specialist recommends a HealthSelectShoppERS-eligible medical procedure or service, you:

1. Log in to Blue Access for Members at **healthselectoftexas.com**, click the "Medical Doctors and hospitals, nurseline, hearing aids" tab, and then the "Find a Doctor or Hospital" link.
2. In Provider Finder, select "HealthSelectShoppERS" to search for a reward eligible location for your doctor recommended procedure or service.
3. From the list of health care providers (facilities) that perform the procedure, follow the prompts to select a lower-cost, quality provider that qualifies for a HealthSelectShoppERS reward.
4. Have your medical service or procedure completed at the HealthSelectShoppERS-eligible facility.

   Note: A referral or prior authorization may be required for your procedure. If you have questions about referrals or prior authorizations, call a BCBSTX Personal Health Assistant toll-free at **(800) 252-8039**, Monday–Friday, 7 a.m. – 7 p.m. and Saturday 7 a.m. – 3 p.m. CT.
5. When your medical service or procedure is complete, your provider will submit the claim to BCBSTX for processing. Once BCBSTX processes the claim and as long as you are still eligible, ERS will deposit your reward into your TexFlex health care flexible spending account (FSA) or limited-purpose FSA. If you do not have a TexFlex health care or limited-purpose FSA before you earn a reward, ERS will open one for you.

You can earn up to $500 in rewards, total per family, each plan year. For more information, please see the HealthSelectShoppERS Frequently Asked Questions at **healthselectoftexas.com → HealthSelectShoppERS℠**.

Confirm network status and costs for doctor visits, lab work, radiology and other services.

- If your doctor orders lab work or imaging, confirm that the lab or imaging center is in your HealthSelect network by calling BCBSTX or visiting the Find a Doctor/Hospital page of **healthselectoftexas.com**.
- Find out how much you might owe for a test before you agree to it.

Confirm network status for facilities, surgery centers and emergency rooms.

- If possible, confirm in advance if the facility, surgery center or emergency room is in your health plan's network. Most freestanding emergency rooms not affiliated with a hospital are not in the HealthSelect network.
- Use Provider Finder to locate in-network emergency room(s) and urgent care facilities closest to your home, work and other places where you spend a lot of time—before you need urgent or emergency care.
- If possible, confirm that all providers involved in your care are in the HealthSelect network. This includes providers of these types of services: anesthesia, pathology, radiology, surgery and surgical assistants. The Where to Go for Care handout at **https://healthselect.bcbstx.com/pdf/where-to-go-for-care.pdf** provides details on how much out-of-pocket costs can vary by provider.
- If you have an actual medical emergency, call an ambulance or go to the nearest emergency room.

For more tips on using your health care dollars wisely and avoiding unexpected health care costs, visit **ers.texas.gov/Avoiding-Unexpected-Health-Costs**.

Know your benefits.

Call a BCBSTX Personal Health Assistant toll-free at **(800) 252-8039 (TTY: 711)**, Monday – Friday, 7 a.m. – 7 p.m. and Saturday 7 a.m. – 3 p.m. CT.

BCBSTX Personal Health Assistants are here to help you understand and use your HealthSelect benefits. They can:

- answer questions about benefits,
- assist with prior authorizations and referrals,
- provide information about programs and benefits available to you,
- help you locate an in-network provider,
- explain health care costs and options for care,
- provide you with cost estimates for services,
- schedule or cancel medical appointments,
- help you use self-service tools and connect you to other resources.

You can also visit **healthselectoftexas.com** to find out more about your HealthSelect benefits, locate an in-network provider, view claims and explanations of benefits (EOBs), and more!

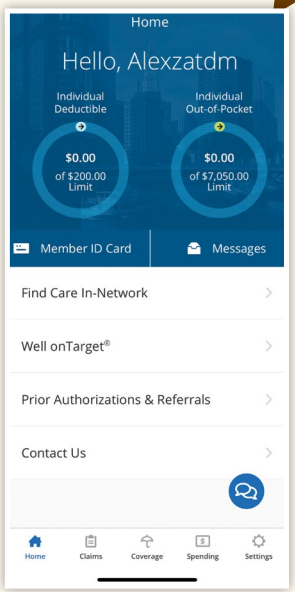
Use emergency rooms for emergencies only.

Did you know that going to an emergency room can cost you more than five times as much as going to urgent care? Did you also know that it can cost the plan 10 times more, sometimes higher? A procedure that costs your health plan $100 in an urgent care facility can cost more than $1,000 at an emergency room. Why should you care? When costs for the plan increase, premiums increase. Help keep costs low. If you have a primary care provider, check to see if they have a same-day office visit available or offer extended hours. Urgent care centers have extended hours for whenever the unexpected occurs. Save money, and save the emergency room visit for life-threatening illnesses and accidents.

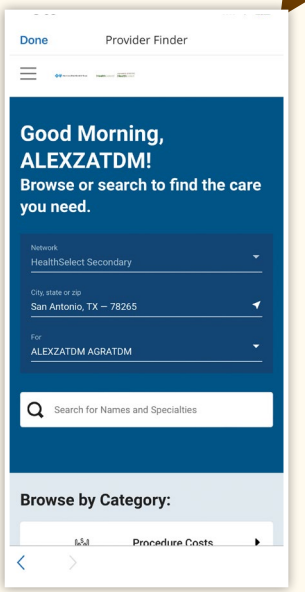
Keep plan information handy with the BCBSTX mobile app.

Download the mobile app by texting BCBSTXAPP to the phone number 33633

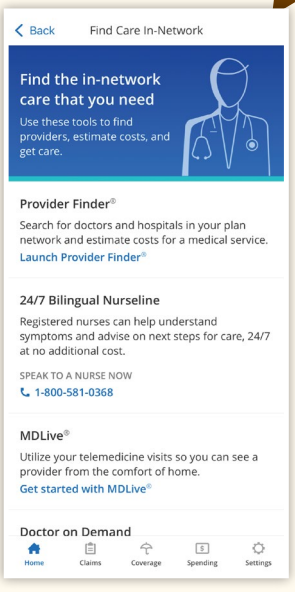
Dashboard



Provider Finder



Care In-Network



Understanding insurance terms

Balance billing	When a patient owes an out-of-network provider for the difference between amount billed by their provider and the amount paid by the plan, after the GBP member pays any applicable deductibles, copays and/or coinsurance. You cannot be balance billed by an in-network provider.
Copay	A fixed amount you pay for a covered health service, usually at the time you receive the service. For example, HealthSelect of Texas has a $25 copay per visit to your in-network primary care provider (PCP) for non-preventive care. If you see your PCP for a sore throat, you will pay $25 before you leave the doctor's office.
Coinsurance	A percentage of the allowable amount for a covered service or product that you are required to pay for covered health care and prescription drug services.
Deductible	The amount you are required to pay for covered health care or prescription drug expenses before your plan begins to pay for any services (except in-network preventive care) each year. If you have a $50 prescription drug deductible, for example, you must pay the full cost of the $50 drug deductible of covered prescription drugs. Deductibles for the HealthSelect plans reset on Jan. 1.
Total out-of-pocket maximum	The maximum amount you and your covered dependents must pay for in-network copays, coinsurance and deductibles within a year. If you reach the out-of-pocket maximum, the plan pays 100% of covered, in-network health expenses for the rest of the calendar year. These maximums help protect you from catastrophic health costs. All health plans have the same total out-of-pocket maximums for covered in-network health and prescription drug costs. The total out-of-pocket maximums reset on Jan. 1 for the HealthSelect plans.
Out-of-pocket coinsurance maximum	The most you are required to pay each year for coinsurance for covered health services. This amount does not include copays. The out-of-pocket coinsurance maximum resets on Jan. 1 for the HealthSelect plans.
Evidence of insurability (EOI)	Proof of good health, established during an application process for certain types of insurance, such as life and disability insurance. During the process, you provide information about your health.
Monthly premiums	The cost you pay monthly for health care coverage.
Plan year	For GBP plans, the plan year is Sept. 1 through Aug. 31. However, certain aspects of some of the plans are based on the calendar year (Jan. 1 – Dec.31).
Third-party administrator (TPA)	The company contracted by ERS to manage certain aspects of many of our benefit plans. For example, Blue Cross and Blue Shield of Texas is the TPA for the HealthSelect of Texas and Consumer Directed HealthSelect medical plans. As such, it manages the provider network, processes claims (ERS pays the claims) and provides customer service. By contracting with TPAs, ERS saves money in administrative costs.

Benefits quick links

The valuable benefits available to you as a state employee are intended to help you care for yourself and your family as you provide vital services to the people of Texas. Health coverage and the retirement plan are competitive with benefits offered by other government and private-sector employers. Optional benefits, such as dental and vision insurance and Texa$aver℠, are funded entirely by participating members. ERS oversees the benefits and contracts with third-party administrators (TPAs) who help manage some aspects of our programs. TPAs help keep administrative costs low to ensure the best value for our members.

Use the following quick links to find details about coverage, eligibility, saving for retirement, wellness, events and other ERS resources. Benefits coordinators or the human resources team at your institution can also answer questions and offer guidance.

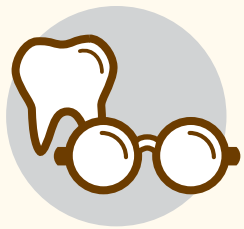
Benefits at a Glance
https://ers.texas.gov/benefits-at-a-glance

New Employee Benefits
https://ers.texas.gov/new-employee

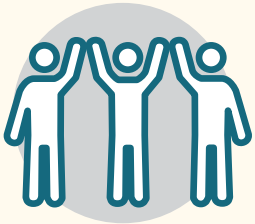
Health Insurance
https://ers.texas.gov/Active-Employees/Health-Benefits

Eligibility
https://ers.texas.gov/Benefits-at-a-Glance/GBP-Eligibility

Texa$aver
https://ers.texas.gov/Active-Employees/Retirement/Benefits-of-Texa$aver-Program



Optional Benefits
https://ers.texas.gov/Benefits-at-a-Glance/Optional-Add-on-Benefits



Wellness Programs
https://ers.texas.gov/Wellness-Resources-en/Wellness-Active

ERS Events
https://ers.texas.gov/Event-Calendars

Contact information

Health Insurance

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	Express Scripts	Toll-free: (800) 935-7189 (TTY: 711)	**www.HealthSelectRx.com**
Consumer Directed HealthSelect health savings accounts (HSAs)	Optum Bank Group number ERS – 001	Toll-free: (800) 791-9361 (TTY: 711)	**www.optumbank.com**

Dental Insurance

Plan	Administrator	Phone number	Website
State of Texas Dental Choice Plan℠ 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 Insurance

Plan	Administrator	Phone number	Website
State of Texas Vision℠	EyeMed Vision Care, LLC Group number – 1050072	Toll-free: (844) 949-2170 (TTY: 711)	**www.StateofTexasVision.com**

Life and accidental death & dismemberment insurance

Plan	Administrator	Phone number	Website
Basic Term Life and AD&D Insurance **Optional Term Life Insurance** **Dependent Term Life Insurance** **Voluntary AD&D Insurance**	Securian Financial Group, Inc.	Toll-free: (877) 494-1716 (TTY: 711)	**www.lifebenefits.com/plandesign/ers**

Short-term and long-term disability insurance

Plan	Administrator	Phone number	Website
Texas Income Protection Plan℠ (TIPP)	Alight, Inc. Evidence of Insurability underwritten by Brown and Brown	Toll-free: (855) 604-6230 (TTY: 711) EOI underwriting questions: **applications@eoisupport.com**	**www.texasincomeprotectionplan.com**

Other programs

Plan	Administrator	Phone number	Website
TexFlex℠	Inspira Financial	Toll-free: (866) 353-9839 (TTY: 711)	**www.texflexers.com**
Texa$aver 457 Plan	Empower	Toll-free: (800) 634-5091 (TTY: (877) 606-4790)	**www.texasaver.com**
Dependent eligibility verification	Alight Solutions	Toll-free: (866) 416-4091 (TTY:711)	**www.yourdependentverification.com/plan-smart-info**
Discount Purchase Program	Beneplace	Toll-free: (800) 683-2886 (TTY: 711) Austin-area local: (512) 346-3300	**discountprogramtxers.com**

Notice of creditable coverage: Plan year 2026

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 enrollment in one of the GBP health plans.

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.

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) 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 HealthSelect 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, 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 drug plans at the same time. If you enroll in a private Medicare prescription drug plan you will no longer be eligible for the HealthSelect Medicare Rx plan and will lose all prescription drug 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.

Notes:

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 (including limited English knowledge and first language), age, disability, or sex. ERS provides people with disabilities reasonable modifications and free communication aids to allow for effective communication with us such as written information in other formats (large print, audio, accessible electronic formats, other formats). ERS also provides free language assistance services to people whose first language is not English such as qualified interpreters, and written information in other languages.

If you need these services, call: **1-877-275-4377, TTY: 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 with:

Attn: Section 1557 Coordinator
Employees Retirement System of Texas
P.O. Box 13207, Austin, Texas 78711.
Phone: **1-877-275-4377; TTY: 711**
Fax: 512-867-3480.
Email: 1557coordinator@ers.texas.gov
For more information visit: https://www.ers.texas.gov

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697

Complaint Forms: hhs.gov/civil-rights/filing-a-complaint/index.html
Complaint Portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

Email: OCRComplaint@hhs.gov

Please visit https://www.hhs.gov/civil-rights/filing-a-complaint/index.html for details.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.
中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电855-710-6984（文本电话：711）或咨询您的服务提供商。
한국어 Korean	주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ (TTY: 711) 855-710-6984 پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

فارسی Persian	توجه: اگر فارسی صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
日本語 Japanese	注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。855-710-6984（TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。
ລາວ Laotian	ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 855-710-6984 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.
Diné Navajo	SHOOH: Diné bee yániłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.

ERS®
Employees Retirement System of Texas

Employees Retirement System of Texas

Always available online at **www.ers.texas.gov**

24/7 access to information about insurance and retirement benefits
To speak to a representative, call (877) 275-4377 (TDD: 711), Monday – Friday, 8 a.m. – 5 p.m. CT.

August 2025