Rules you should know

Deferred retired employees

If you are eligible to receive a pension within five years after you terminate employment, you are a deferred retired employee. Deferred retired employees may keep their medical and dental coverage for themselves and their covered family members. You may keep life insurance for yourself. You will pay the same premiums that retirees pay. If you don't pay your premiums, you will not be allowed to reinstate coverage when you begin receiving a pension.

Long term disability

If you were hired after September 1985 and are an active municipal employee or classified firefighter, you are covered under the Compensable Sick Leave Plan. After two years of employment, you are usually covered under the Long Term Disability Plan. If you become disabled, you must apply for your disability benefit within 12 months after the disability caused you to stop working. You may qualify to receive the benefit until age 65.

Life insurance

Review your life insurance beneficiary. If you have had a "life event" like marriage, divorce, birth, adoption, or death, you may want to change your beneficiary. If your minor child is the beneficiary of your life insurance, the life-insurance company will keep that money until your child reaches age 18, or until the insurance company receives legal documentation showing a financial guardian for your child. An employee is the beneficiary of his/her dependents' life insurance.

If your spouse and you work for the city, both of you have employee basic life insurance of one times your annual base salary. You may not be your spouse's dependent under the life insurance plan. Check your benefits file to ensure your city-employee spouse is not a dependent for the basic or voluntary coverage. Only one of you may cover dependent children.

You may buy life insurance up to four times your base salary. If your spouse does not work for the city, the maximum coverage is $50,000. A child's maximum coverage is $10,000.

Medical/Dental coverage

If you die while you are an active employee, your covered surviving spouse and covered dependent children may keep medical and/or dental coverage until your spouse remarries or becomes covered under another group medical or dental plan. The children may be covered until age 25. Your spouse will pay premiums based on "employee rates," until your spouse remarries and/or becomes ineligible for coverage.

COBRA

If you are covered under the benefits plans when you terminate employment, you may keep your medical and dental coverage for 18 months through the Consolidated Omnibus Budget Reconciliation Act. You will pay the total premium. If you become disabled during that period, you may keep COBRA benefits for 29 months, when you should qualify for Medicare.

No paycheck? Keep your benefits

If you are an active employee and you do not receive a paycheck from the city but want to retain your benefits, you must pay your premiums directly to the benefits division at 611 Walker, 4th floor. Premiums are not deducted for your benefits from the check that you receive from the workers' compensation carrier.

What's in your benefits file?

You may review your benefits file at 611 Walker, 4th floor, weekdays, 8 a.m. – 5 p.m. Because your records are confidential and protected, a written request, a written release with your notarized signature, or your physical presence is required. Present your city ID card. Information will not be released over the telephone.

Change of address

Active employees

When you change your mailing address, you need to also update your address with the city's central payroll division, and complete a benefits change form for the medical/dental plans. To receive important information about your medical and dental plans, your address must be current at all times.

Retirees

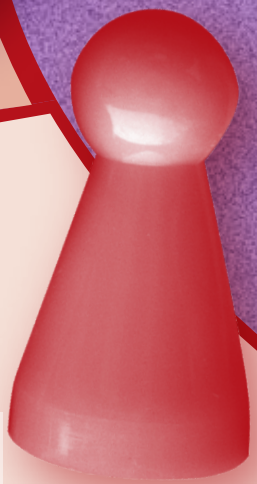
When you change your mailing address, you need to change it with your pension office and the Benefits Division. To receive important information about your medical and dental plans, your address must be current at all times.

Small pension check? Pay your premiums by cashier's check or money order

If you are a retiree and find that you need to pay your health-care premiums by cashier's check or money order, you may do so. Contact the Benefits Division at (713) 837-9400 or (888) 205-9266.

Win for Life

Making SMART health choices



Employee and Retiree Enrollment Guide

City of Houston
May 2008

Suitable for all covered members of all ages
1 or more enrollees required

A message from the Mayor

Dear employees and retirees:

Every day we read and hear about rising health-care costs, and employers facing the difficult decision of whether to continue offering health benefits to their employees and retirees. Preserving the City's benefits plans in these tough financial times is very important to me, and I believe that by working together, we have been successful. Often times, changes must be made to our plans to help keep them affordable, but I am happy to say that for the second year, no changes to the benefits plans will occur for May 2008. This is because you continue to use your health care dollars wisely and efficiently by making cost-conscientious choices – using generic and mail-order prescription drugs, using urgent care centers instead of emergency rooms, getting annual physical exams, exercising, engaging healthy lifestyles, and eating nutritious foods.

However, the rising costs of health-care services have created an increase in the city's medical plan costs from $248 million in FY08 to $276 million in FY09. State-of-the-art medical procedures, equipment, and specialty drugs do much to improve our quality of life, but are very costly. To keep on track with this large expense, sustain the plan's current benefit levels, and maintain the current contribution ratio of 74 percent for the city and 26 percent for the participant, the city will share the cost increase with you. At the same time, your dental and supplemental insurance rates are locked in until April 2009, so you will not experience any cost increases or changes to these benefits. The maximum contribution to the Healthcare Flexible Spending Account will increase to $2,000 from $1,000.

Specific information about your benefits and the new rates are provided in this guide. If you have questions, please see your HR Liaison or attend an open enrollment meeting. You can obtain a meeting schedule online at www.houstonhumanresources.org.

If we continue to work together, we should be able to retain quality, accessible and affordable health-care benefits. Thank you for appreciating your valuable benefits and for continuing to use them effectively.

Respectfully,

Bill White

Mayor

Who's in the game?

Who	HMO	PPO	Total
Employees	20,190	570	20,760
Retirees	6,813	515	7,328
Dependents	37,296	555	37,851
MA enrollees			2,055
Total	**64,299**	**1,640**	**67,994**

Date: Oct. 2007

Employee Wellness Fair

GEORGE R. BROWN CONVENTION CENTER
EXHIBIT HALL B

Thursday, April 24, 2008
9 a.m. to 2 p.m.

WELLNESS SCREENINGS

GOODIES AND FUN

DOOR PRIZES

FITNESS DEMONSTRATIONS

Free parking in lots 1 and 2 with city ID badge or this announcement.

Contacts

City of Houston Benefits Division
(713) 837-9400
(888) 205-9266

City of Houston Web site
www.houstonhumanresources.org

HMO Blue Texas in the Benefits Division
(713) 837-9376
(713) 837-9377
(713) 837-9448

HMO Blue Texas
(866) 757-6875
www.bcbstx.com

Prime Therapeutics (HMO Blue Texas)
(877) 357-7463
www.myrxhealth.com

United Healthcare Dental
(866) 605-2599

24/7 Nurseline
HMO members (800) 581-0353
PPO members (800) 581-0368

Municipal Pension
(713) 759-9275

Fire Pension
(281) 372-5100

Police Pension
(713) 869-8734

Great West (Deferred Compensation)
(713) 426-5588

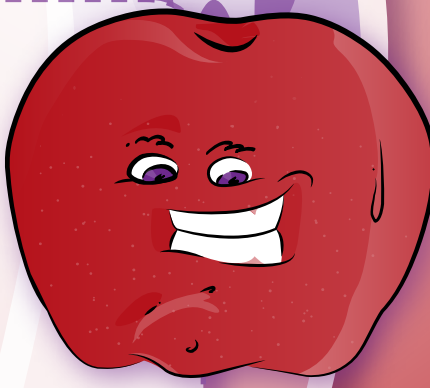
You're a winner!

Winning: it's really about you

Congratulations! Look at yourself, now. You're getting stronger, sharper, more focused and effective. Sure, you've always cared about your health. But the role your lifestyle plays is becoming clear. You've learned that when your lifestyle is healthy, you are healthy with higher energy levels.

Continue living a life making balanced choices about better nutrition, maintaining an acceptable weight range, reaching new levels of fitness and motivation. That's the biggest secret for winning the biggest game of all: life.

So bid farewell to fatigue, sayonara to smoking and aweigh to unwanted weight gain. The rest of your life starts here. Stay the course and keep winning.



The city of Houston reserves the right to change, modify, increase or terminate any benefits.

More Rules of the Game

How to enroll or make changes

Employees: If you want to enroll or make changes to your current coverage, ask your department human resources liaison for an enrollment or change form.

Retirees: Use the medical or dental change forms in your enrollment packet and mail to the:

Benefits Division
P.O. Box 248
Houston, TX 77001

If you don't enroll now — active employees

If you do not enroll for benefits during open enrollment, you may apply during the year for coverage in the HMO plan by completing a medical/dental election form. Your coverage will be effective on the first or the 16th of the month following the 90-day waiting period from the date you submit your enrollment form. You may not enroll in the PPO or dental plan until open enrollment in 2009, unless you have a qualifying family status change through loss of other group coverage.

Life insurance — active employees

You may apply for voluntary group life insurance at any time. If you apply for first-time coverage or increase your coverage during this enrollment period, you must complete a personal health statement. You will begin paying premiums after the insurance company approves your application.

Important Note

Your completed forms must be given to your department human resources liaison by the last day of the enrollment period. The open enrollment period ends April 21, 2008. Any changes you make will be effective May 1, 2008.

Retirees should use the postage-paid envelope in their packet to return their completed forms, or use the address above.

Employee Self Service at your service — online tool for reviewing your personal record

Thousands of employees have logged into the Employee Self Service system. This is a convenient way to look up information in your personal record.

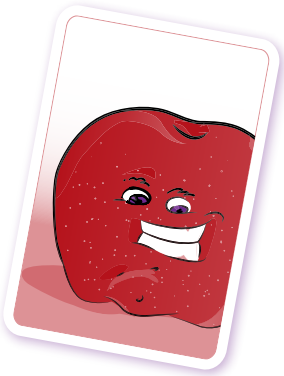
You can access current leave balances and usage, deductions, and some paycheck stubs. You will also find forms to print and links to sources of information for city employees. It is a secure site, accessed through the Internet, which means you can login from any Internet location, your home, your PC at work, or the public library. Employees have access to only their own information.

If you are a new user, you will need to set up your password. Select "first time user" and follow the instructions (enter your 6-digit employee number and enter a password). When you login, the menu choices are on the left side of the screen, in the blue bar.

Here's the link:
http://www.houstontx.gov/ess

If you have questions about your personal information, print the page and check with your Payroll Representative or HR Liaison. If you experience technical problems, contact the IT help desk. If you have comments or suggestions, e-mail them to the Contact Us address.

Just one more way we're trying to provide more information at your fingertips.



Enrollment

Here's how your benefits package looks:

Health plans

- HMO
- PPO
- Plan A (for grandfathered retirees)
- Three Medicare Advantage plans for Medicare-covered retirees and their dependents

Dental plans – employee paid

- Dental HMO
- Dental indemnity plan

Supplemental Insurance plans – employee paid

- Cancer
- Hospital
- Accident / disability

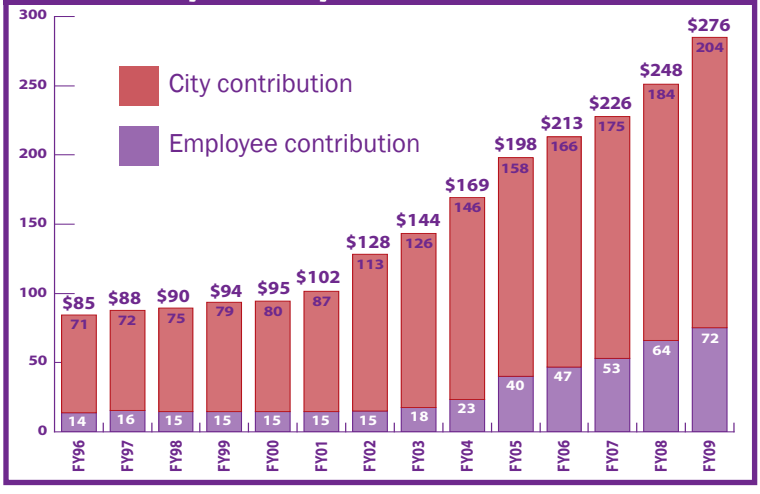
Flexible Spending accounts

- Health Care
- Dependent Care

In addition, these plans are offered outside this open enrollment period.

- Life insurance – one-times salary, paid by the city
- Voluntary life insurance – up to four times salary, employee-paid
- Time off, including holidays, vacation, sick, wellness leave, personal days, for most employees
- Long term disability, paid by the city, for most employees
- Pension – valuable defined benefit plan; unique plans for civilians, police and fire classified employees
- 457 pretax deferred compensation savings plan
- Subsidized transportation benefit

Health plan expenditures in millions



*Estimated

What's new for May 2008 ?

- The maximum contribution to the Healthcare Flexible Spending Account has increased to $2,000 from $1,000. See page 16 for details.
- Outpatient benefits are improved for rehabilitation, speech, occupational and physical therapy. See page 4 for details.
- Inpatient benefits are improved for rehabilitation, speech, occupational and physical therapy. See page 4 for details.
- Benefits are provided for autism spectrum disorder. See page 4 for details.
- Pervasive developmental disorders are moved from the definition of serious mental illness to autism spectrum disorder. See page 4 for details.
- Your contributions to the medical plan will change. See pages 7 - 8 for details.

Contents

Health Plan Highlights

Plan highlights

There are no benefit changes for May 2008!

We are happy to announce there are no changes to the medical plans for the 2008 plan year. Your health care contributions will increase.

The HMO and PPO plans offer a choice of plan that delivers comprehensive accessible care, and predictable and budgetable health costs.

The HMO requires that all of your care be directed by your Primary Care Physician and you must use network providers, except in the case of emergency. There is more flexibility in the PPO, more doctors, no PCP requirement, and the option to go out-of-network. The trade-off is that you pay more for this flexibility, in your contribution and at the time of service.

You are familiar with the features of these plans, which are summarized in the chart on this page. These plan features have not changed since May 2006. A detailed comparison is provided at **www.houstontx.gov/hr/oe08**, or with your enrollment materials.

Type of service

Copayments for primary care services and specialist services are determined by the type of service.

- If the service is performed by the primary care provider in the office, the lower copayment will apply, $20 in the HMO and $30 in the PPO.
- If the service is performed in a specialist's office, or in another location, the higher specialist copayment will apply, $45 in the HMO and $50 in the PPO.

Services such as home health visits, family planning and infertility treatment, physical therapy and other similar services are "specialist services," and you will pay the higher copayment.

Covered by Medicare?

To help you win financially, retirees who are covered by Medicare should consider a Medicare Advantage Plan. See page 6 for additional information.

Health plan features at-a-glance

Plan feature	What you pay		
	HMO	PPO In-network	PPO Out-of-network
Deductible (Individual/Family)	no deductible	$200/$600	$400/$1,200
PCP office visit copayment	$20	$30	40%
Specialist office visit copayment	$45	$50	40%
Routine physical copayment	$0	$0	40%
Well woman/man exam	$0	$0	40%
Inpatient admission copayment/coinsurance	$500	$500 + 20%	$1000 + 20%
Emergency room	$150	$150 + 20%	$150 + 20%
Ambulance Outpatient Surgery	$100	20%	20%
Outpatient surgery	$200	20%	40%
Prescriptions* (30-day supply) participating pharmacy copayment			
Generic*	$10	$10	$10
Preferred brand	$30	$30	$30
Nonpreferred brand	$45	$45	$45
Prescriptions* (90-day supply) mail-order copayment			
Generic*	$20	$20	$20
Preferred brand	$60	$60	$60
Nonpreferred brand	$90	$90	$90
Annual maximum copay/coinsurance (Individual/Family)	$1,500/$3,000	$3,000/$6,000	$5,000/$10,000

*Generics are mandatory, if available.

Qualified family status change

If you are an active employee and pay for coverage with pretax dollars, you may change your coverage during the year only if you have a qualified family status change.

Qualified family status changes include:

- marriage or divorce,
- birth or adoption of a child,
- death of a dependent,
- a dependent child reaches age 25, or marries,
- a spouse's loss of employment,
- a spouse becomes employed and enrolls in that employer's benefits program,
- you or your spouse change from full-time to part-time employment or vice-versa, or you experience a significant change in your spouse's benefits or premium payments,
- a dependent loses Medicaid medical coverage.

If you have a family status change, you must submit a status change form and documentation within 31 days of the change. See the "Required Documentation to Add Dependents" section on page 19.

Important Note

When your dependents become ineligible, they will be dropped from coverage. You must submit a status change form within 31 days.

You will receive a refund of the premiums you paid for coverage only from the date of your notification.

If they are not dropped on time, they are still ineligible for coverage. You will not get a full refund beyond 60 days, and you may be responsible for any claims incorrectly paid on their behalf.

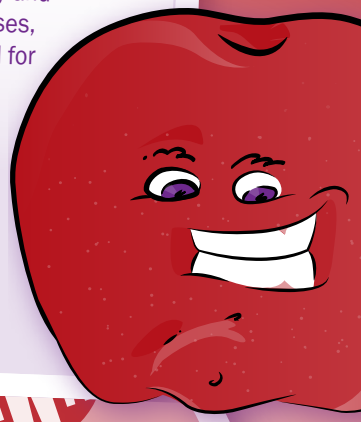
You can get a status change form from your department human resources liaison or the Benefits Division at 611 Walker, 4th floor.

Apple A. Day Card

You brush your teeth twice a day, clean between teeth with floss or an interdental cleaner once a day and visit your dentist regularly. **Move your bright white smile forward three squares.**

Proper hygiene saves your teeth, eliminates the pain, anxiety and discomfort of dental diseases, avoids or reduces the need for periodontal surgery, saves money and saves time, the American Dental Association states.

Game tip: Your dental plan covers two cleanings per year. Take advantage of them for cleaner teeth and fresher breath.



Apple A. Day Card

Reduce stress. The captain knows it's easier said than done, but stress busters come in many forms.

Try to spend 30 peaceful minutes each day. Soak in a hot tub; walk in a park; visit a friend or read a good book.

Think happy thoughts and float forward two squares.

Apple A. Day's thought for the day: Count to 10 before losing your temper or getting aggravated.

Rules of the Game

Who is eligible?

You are eligible for coverage under the benefits plans if you are:

- A full-time employee or a part-time employee regularly scheduled to work at least 30 hours a week;
- A retiree who was covered by a city medical plan on the date of retirement from the city;
- A survivor of a covered city employee or retiree, up to age limits and application of other plan rules; or,
- A deferred retired employee who will become eligible to receive a pension within five years after termination and continuously pays the monthly retiree contribution for health coverage.

If both you and your spouse work for the city, you may be covered as an employee or as a dependent — but not both. Dependents may be enrolled under only one parent or guardian.

Eligible dependents

Eligible dependents are your:

- Legal spouse,
- Unmarried natural or adopted children up to age 25, if they qualify as dependents for federal income tax purposes,
- Children up to age 25, over whom you have legal guardianship or legal foster care if they qualify as dependents for federal income tax purposes,
- Grandchildren under age 25 if they qualify as your dependents for federal income tax purposes,
- Disabled dependents over age 25 who are incapable of self-sustaining employment because of mental retardation or physical handicap. The dependent must be primarily dependent on you for more than 50 percent of financial support and approved for coverage after age 25.
- Unmarried dependent children who lose Medicaid coverage may be enrolled under the employee's medical plan within 31 days after Medicaid coverage is lost. They may be covered to age 25 if they qualify as the employee's dependent for federal income tax purposes.

Required documentation

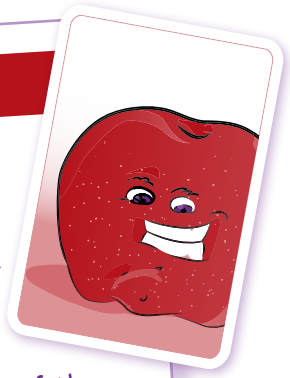
To add dependents for coverage, you must submit the required documents. The following is a list of documents you must provide with your medical/dental election or change form by the open enrollment deadline.

- Spouse — copy of a certified marriage license
- Common-law spouse — Declaration and Registration of an Informal Marriage Certificate
- Children up to age 25, over whom you have legal guardianship or legal foster care — copy of the legal documents that gave custody, guardianship or foster care
- Grandchild(ren) up to age 25, who are your covered dependents for federal income tax purposes — the Financial Dependency of Children form and a birth certificate
- Disabled dependents over age 25 if they were covered before age 25 and are primarily dependent on you for more than 50 percent of their financial support — medical documentation of the disability or mental handicap
- Children under age 25, if not added at time of birth or if you are requesting reinstatement of their coverage — a birth certificate or legal document that establishes paternity of the employee and a completed certification of Financial Dependency of Children form

There is no waiting period for dependents added during open enrollment.

Important Note

If you are enrolled in the HMO plan, and you do not add a new dependent within 31 days of the event, you may add the dependent later, but there will be a 90-day waiting period. Coverage will be effective on the first or the 16th of the month following the waiting period. You may add a dependent to the PPO within 31 days of the event or during annual open enrollment.



The 80th Texas Legislative Session, held in 2007, mandated HMOs provide the following benefits and enhancements, effective May 1.

BlueCross BlueShield of Texas' annual notification package will include the updated HMO Certificate of Coverage for these benefits.

New or improved benefits

What's new	Benefit	Copayment
Improve outpatient and inpatient services for rehabilitation, speech, occupational and physical therapy.	Provide post-acute care treatment for periodic reevaluation for a member who (1) has incurred an Acquired Brain Injury; (2) has been unresponsive to treatment; and (3) becomes responsive to treatment at a later date. Services may be provided at a hospital, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.	Member HMO and PPO copayments and coinsurance will apply to these services.
Autism Spectrum Disorder - A neurological disorder that includes autism, Asperger's syndrome, or pervasive developmental disorder – not otherwise specified. New benefit for children up to age six.	New Benefit for children up to age six. Services may be provided by a health-care practitioner: (1) who is licensed, certified, or registered by an approved agency of the state; (2) whose professional credential is recognized and accepted by an approved agency of the United States; or (3) who is certified as a provider under the TRICARE military health system. Treatment may include services such as: Evaluation and assessment services, applied behavioral analysis, behavior training and behavior management, speech therapy, occupational & physical therapy, and medications or nutritional supplements used to address symptoms of Autism Spectrum Disorders. After age six, covered services are available.	Member HMO and PPO copayments and coinsurance will apply to these services. In the HMO, there isn't a maximum benefit. In the PPO, the plan's maximum benefits will apply.
Pervasive developmental disorders	Moved from the definition of Serious Mental Illness to the definition of Autism Spectrum Disorder.	Member HMO and PPO copayments and coinsurance will apply to these services.
Autism Spectrum Disorder	The definition of this condition has been added to the plan.	

Winning Tip

The PPO in-network has an annual deductible of $200 for individuals and $600 for families. For families, the maximum can be reached by a combination of all covered family members' eligible expenses.

If you don't reach your annual deductible by Sept. 30, a three-month carryover feature will help you in the following calendar year. Charges that apply to the annual deductible and that are incurred in October, November and December can be counted in the next year.

Enrollment Options

If you are currently enrolled in:	You may enroll in one of these plans during this enrollment		
	HMO	PPO	OOA**
HMO	yes*	yes	no
PPO	yes*	yes	no
OOA	yes*	yes*	yes**

* If you live in the plan's service area.
** Only available to a few employees/retirees. You must live outside the PPO/HMO service area to enroll. See a list of zip codes on the enrollment Web site.

Health Materials Checklist

Employees

- ☐ Statement of benefits
- ☐ Open enrollment guide
- ☐ Comparison chart
- ☐ Election/change forms

Retirees

- ☐ Open enrollment guide
- ☐ Comparison chart
- ☐ Medical/Dental change form

Health Plan Highlights

Which doctors can help you win?

This chart is a partial listing of doctor groups in the HMO and PPO. Many doctors contract independently with the PPO. For a complete list, go to **www.bcbstx.com** and search by doctor name or by zip code.

Doctors in the HMO and PPO

Physician Group	HMO	PPO
Baylor	*	X
CardioVascular Care Providers, Inc.	††	X
Independent Physicians, if listed	X	
Inpatient Consultants of Texas		X
Kelsey-Seybold Clinic	X	X
The Limited Provider Network	X	**
MD Anderson Cancer Center	††	X
Medical Clinic of Houston		X
Memorial Hermann Healthnet Network Providers	†	X
Northwest Diagnostic Clinic	X	X
OB/Gyn Associates		X
Renaissance	X	**
Sadler Clinic	X	X
UT Physicians		X
UTMB-Galveston		X

X The physician group is in the HMO or PPO. * Pediatricians/specialty care providers participating in the HMO. ** Physicians in these groups may be in the PPO through independent contracts instead of through the IPA. † Physicians may be in the HMO through independent contracts instead of through the IPA. †† Available through referral only.

Apple A. Day Card

Cut the fat. **Lean forward three squares.** You avoid the obvious fried foods and fatty meats such as pork, bacon, ham, salami, ribs and sausage.

Dairy products such as cheese, milk and cream should be eaten in the lowfat versions.

Sandwich meats, mayonnaise, margarine, butter and sauces should be eaten in limited amounts and may be substituted for lower fat versions.

Apple A. Day's thought for the day: Be a lean, fat-burning machine.

Which plan is right for me?

Features	HMO	PPO
	You must select a PCP. Services are available from specific doctors for a specific copayment; no claims to file; no coverage out-of-network (except for emergencies.)	Services are available from a large network of doctors; services are subject to deductible, copayment and coinsurance; you may have to file a claim; out-of-network coverage is available at a lower benefit level.
Network	7,055 PCPs and 28,793 specialists for a total of 35,848 HMO doctors in Texas.	10,837 PCPs and 38,959 specialists in 254 counties in Texas, and 720,000 participating physicians across the United States.
Service Area	220 counties in Texas.	All 50 states, plus Puerto Rico.
Network services	Except for emergency care, only services provided in the network are covered.	Services performed in-network and out-of-network are covered at different levels.
Primary Care Physician	Your PCP coordinates all medical care.	Freedom to chose any doctor, hospital, or specialist.
Referrals	PCP must refer you to specialists and hospitals.	Referrals are not required.
Deductible	No deductible or coinsurance.	$200/$600 in-network. $400/$1,200 out-of-network.
PCP visit	Most common copayment is $20.	Most common copayment is $30 in-network.
Specialist visit	Most common copayment is $45.	Most common copayment is $50 in-network.
Coinsurance	Most services covered at 100% after copayment.	Services covered 80% (or 60% out-of-network) after annual deductible.
Billing for services	No balance billing. No claims to file.	No balance billing, unless you seek out-of-network services; you must file a claim to seek reimbursement.
Preventive care	Routine preventive care such as well-baby, well-woman, and well-man exams are free; annual physicals are covered with $0 copayment.	Preventive care such as well-woman and well-man exams are free in-network and annual physicals are covered with $0 copayment. Limitations on out-of-network preventive services.

Section 125

All employees enrolled in medical, dental, and supplemental insurance products have deductions taken on a pretax basis.

The one exception is for those enrolled in the voluntary disability benefit. Deductions for that benefit are post-tax, so that any disability benefit you receive from it is not taxable.

What does Section 125 mean to me?

Paying for your deductions on a pretax basis will reflect a lower "taxable earnings" figure on your W2 – and that means you pay taxes on a lower amount – and that usually means less taxes!

In many cases, you see an increase in your take-home pay.

Changes to your benefits are limited to Open Enrollment periods, unless you have a qualified change in family status. The change in benefits must be consistent with the status change. See the Qualified Family Status Change information on page 20 to learn more.

Here's the math

This is an example of how you may benefit from paying for benefits with pretax dollars. The example is based on a married couple with three withholding allowances in 2008.

Example of Pretax deduction savings

Pay/Deductions	Pretax	Post-tax
Gross biweekly pay	$1,250.00	$1,250.00
Employee pretax HMO premium	-$115.76	$.00
Employee pretax DHMO premium	-$13.20	$.00
Taxable income	$1,121.04	$1,250.00
Federal withholding	-$71.72	-$84.61
Social Security withholding	-$85.76	-$95.63
Emp. post-tax HMO medical premium	$.00	-$115.76
Emp. post-tax DHMO dental premium	$.00	-$13.20
Net biweekly pay	$963.56	$940.80
Biweekly increase in take-home pay	**$22.76**	**$.00**
Annual increase (24 checks) in take-home pay	**$546.13**	**$.00**

Winning Tip

Don't forget the pretax Healthcare Flexible Spending Account. You must re-enroll if you want to continue. Learn more about it on page 16.

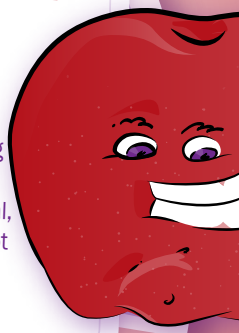
Winning Tip

If you are enrolled in the medical, dental or supplemental insurance plans and don't want to make any changes - don't do anything. Your coverage will remain in effect through April 30, 2009.

Apple A. Day Card

You feel like a snack, so you go to the vending machine and buy a candy bar. Fall back two squares.

Rather than munching on sugary candy or fattening chips from the vending machine, reach for some fruit or vegetables. Carry a small container of natural, healthy food with you so you're not caught hungry with just a vending machine offering relief.



Wellness

Staying on top of your game

Use your health plans wisely and stay healthy. They offer wellness exams, screenings, immunizations, information and management resources that cost you little or nothing. Did you know your health plan provides a $0 copayment for well-man, well-woman screening or annual physicals? Or that the DHMO offers preventive dental services for $0 copayment?

In addition to these health plan features, the city offers several avenues of access to wellness activities.

Blue Access: Provides online access at **www.bcbstx.com** to important information for health plan members about their coverage. Members can use the Personal Health Manager to set up a personal health record and receive wellness advice for you and your family members.

Special Beginnings: Is a prenatal education program to help expectant mothers better understand and manage their pregnancy. An introductory video is available in English and Spanish. To enroll call (800) 462-3275.

Personal Health Manager: Did you ever wish for a personal trainer to help design a fitness program just for you? If only you had a nutritionist to find the calorie pockets in your fast-food lunch. Well, here they are! Online resources to personalize a program for you. How about daily medals for reaching your goal? Log on through Blue Access and click on Personal Health Manager to start making some SMART choices.

24/7 Nurseline: Call this number 24/7 for health issues that come up when you can't reach your doctor: (800) 581-0353/HMO members or (800) 581-0368/PPO members.

Wellness Leave: Compensable Sick Plan gives eight hours of paid time-off for preventive wellness activities in a benefit year, Sept. 1 – Aug. 31. Activities include dental, vision, well-woman, well-man and physical exams, as well as other wellness-related doctor visits. Contact your HR liaison for information.

50 free fitness facilities: You don't have to pay your way to fitness. The city offers free memberships in city facilities all over Houston. You ride stationary bikes, lift weights, swim, play basketball or play tennis. To view a chart of facility locations and services visit **www.houstonhumanresources.org** and click on Benefits Alert.

Apple A. Day

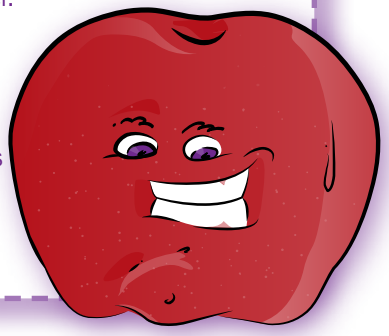
Move more. You begin a daily fitness program by challenging yourself to find inventive ways to get exercise.

Climb three squares forward.

Remember, anything that moves your limbs is a fitness tool and a stress buster.

It doesn't have to be an hour spent at a gym. Just climbing the stairs instead of taking the elevator or escalator is a step in the right fitness direction.

Apple A. Day's thought for the day: Move it!



Health Risk Assessment

Get a $50 gift card just for completing your Health Risk Assessment. More than 2,700 of your co-workers have already taken advantage of this one-time opportunity.

It's easy. Log on to www.bcbstx.com and click on the Personal Health Manager. Then click on Health Risk Assessment. Complete your HRA and authorize its release to BlueCross Blue Shield, and in about six weeks, they'll send you a $50 gift card* to Academy in Texas or The Sports Authority for non-residents.

The assessment is a short series of easy-to-answer questions. You'll then receive an evaluation of your overall health along with scores on your medical health, job satisfaction, risky lifestyle choices, stress, nutrition and even sleep habits.

Of course, you'll be winning a much bigger prize by getting important guideposts to making healthier lifestyle choices.

*Only one card per employee/family. It's a good idea to complete the HRA every year, or as often as you like, but you will be eligible for the gift card only once.

Medicare Advantage

Are you or your dependents covered by Medicare?

Get ahead of the game with a Medicare Advantage plan. You now have the choice of three MA plans; Aetna Private-Fee-for-Service, TexanPlus and Texas HealthSpring.

What's the difference in these three city-sponsored MA plans?

Aetna Private-Fee-for-Service offers copayment benefits for most services in all 50 United States. Any doctor and hospital that accepts Medicare assignment and Aetna's terms and conditions can participate. There is no network, no directories, and no referral is required to see a specialist.

TexanPlus offers HMO-type benefits to Medicare-covered retirees in the southeast Texas area. The network includes Kelsey Seybold and Heritage doctors from which to select a PCP.

Texas HealthSpring offers HMO-type benefits to Medicare-covered retirees in the southeast/east Texas areas and three counties in the Valley. The network includes Kelsey Seybold, Sadler Clinic and Renaissance doctors from which to select a PCP.

Some of the exceptional benefits are:

- TexanPlus and Texas HealthSpring have plan designs similar to HMO Blue Texas HMO.
- Kelsey Seybold doctors participate in TexanPlus and Texas HealthSpring in the Houston area.
- Renaissance and Sadler doctors participate in Texas HealthSpring and Heritage doctors participate in TexanPlus.
- Aetna offers the possibility that 96% of the doctors in the U.S. that accept Medicare assignment will belong to their PFFS plan. PCP selection is recommended, but not required.
- All three plans have prescription benefits similar to the HMO and PPO drug copayment structure.
- Access to familiar retail pharmacies like CVS, Walgreens, HEB, Kroger, Randalls and others.
- Access to state-of-the-art medical facilities like St. Luke's and Methodist Hospitals.
- Urgent-care center locations so convenient they could almost be considered a house call.
- The option for split-family elections – one stays in HMO or PPO, one elects a Medicare Advantage plan.
- Opportunity to switch back to the HMO or PPO within 90 days of enrollment in an MA plan, or on January 1, 2009 and again on May 1, 2009. If you are interested in one of the MA plans, call (713) 837-9400 or (888) 205-9266 for a copy of the Medicare Advantage guide.

To access the medical plan documents visit www.houstontx.gov/hr/oe08/

Savings? Show me the money!

Savings come in the form of lower monthly contributions, and lower time-of-service payments. Since May 1, 2005, almost 2055 participating retirees and dependents have saved more than $2.7 million in contributions. That doesn't count what they've saved in copayments. Here's how the savings stack up:

- If you are in the HMO, and enroll in one of the three MA plans, you could save as much as 95 percent over what you're paying for HMO coverage.
- If you are in the PPO, and enroll in the Aetna PFFS plan, you could save 89 percent over what you're paying for PPO coverage.
- Lower out-of-pocket costs on many services including:
  - 25 - 70 percent on doctor visits
  - $200 - $500 on hospital admissions
  - $100 on emergency room visits
  - 5 - 10 percent on durable medical equipment, like wheel chairs and walkers
  - 100 percent coverage for home health visits
  - Free rides to the doctor if you enroll in Texas HealthSpring: up to 15 round trips to doctors, hospitals, pharmacies

How do I get in the game?

If you or your dependent(s) are card-carrying members of Medicare and are enrolled in both Part A, hospital insurance, and Part B, medical insurance, contact the city of Houston benefits division at (713) 837-9400 or (888) 205-9266 for more information regarding these money-saving Medicare Advantage Plans.

Request the separate enrollment guide and more information about the plans at www.houstontx.gov/hr/oe08/.

Health Plan Contributions

Contributions

Each year, we struggle to achieve the right balance of benefits and contributions. We expect to spend $276 million for health care in FY09. That buys a lot of valuable health care for 68,000 employees, retirees and dependents, but that expense is rising faster than income in the city's General Fund.

To keep the plans affordable and secure this year and in future years, participant contributions will increase May 1, 2008.

Contributions for May 2008 were calculated according to these four steps, in order:

- All HMO rates increased 9.63 percent.
- Retirees under age 65 contribute a greater portion than employees and other retirees because claims for that group are higher and growing.
- Active employees who cover dependents still pay $20 more per month for dependent coverage.

This contribution calculation has the least effect on active employees — our primary concern. If you have a working spouse, we encourage him/her to enroll in their employer's health plan, if available.

These calculations will result in a contribution ratio of 74 percent city, 26 percent participant. Here's what it means to you:

- Employees with dependents still pay $20 more per month.
- Retirees under age 65 pay a higher share of the premiums because they have higher claims experience.
- HMO contributions will increase 9.63 percent.
- PPO contributions will increase 24.3 percent, on average.
- Medicare Advantage plan contributions will not increase now.
- The overall increase is 10 percent.

These changes will help secure these options for future years — preserving the "benefit-for-contribution" equation. Compare the rates on page 8 to the chart to the right. You still pay less for health care than your neighbor. Retirees still have access to several options that provide comprehensive coverage for low cost.

Disease Prevention Discount Program

Studies show that people who use tobacco are more likely to have higher medical claims and are hospitalized longer. They are also more likely to have smoking as a primary contributor to illnesses like heart, lung and pulmonary diseases that generally require long-term and costly medical intervention.

For these reasons and others, employees, retirees and their covered dependents who do not use tobacco receive a $25 discount each month. If you are paying the disease prevention discount premium and cover a tobacco product user, you could lose medical coverage.

Apple A. Day Card

You're thinking about quitting smoking, so you consult with your doctor about your options.

Drift forward three squares.

There are an array of products that can help you quit: the nicotine patch, nicotine gum, nicotine lozenges, nicotine inhaler, nicotine nasal spray, and bupropion, an antidepressant drug that can help control nicotine cravings. Select the method that works best for you.

Game tip: The medical plans can help you win this game – and help your wallet win, as well. The HMO and PPO plans cover prescription drugs for smoking cessation. The benefit is $185, limited to one course of treatment annually.

Monthly rate comparison among local employers

Company (Predominant Plan)	Tier	Employee's Contribution	Employer's Contribution
City of Houston (HMO)	EE only	$34	$296
	EE+ family	$232	$816
Rice University (HMO)	EE only	$60	$314
	EE + family	$382	$773
HISD (Consumer Plan)	EE only	$47	$288
	EE + family	$490	$314
Harris County (PPO)	EE only	$0	$424
	EE + family	$357	$762
Private Local Company (PPO)	EE only	$100	$300
	EE + family	$314	$852

Source: City of Houston annual health benefits survey, January 2008. City of Houston data effective 5/1/08. Other participants' data valid YTD 2008.

Flexible Spending Account

Healthcare Flexible Spending Account – a SMART choice

You asked for another way to save money — and we delivered. **We've increased the maximum you can contribute to your Healthcare Flexible Spending Account to $2,000.** The HFSA is a voluntary pretax benefit plan that allows you to set aside money from your paycheck to pay for out-of-pocket medical, prescription, dental and vision expenses incurred by you and your family.

More than 670 of your co-workers signed up for the HFSA last year and saved money on eyeglasses, dental deductibles, prescriptions and other medical expenses. They contributed an average of $744 for the year and more than 300 participants contributed the maximum $1,000. The maximum is now $2,000. Be sure to ask for the HFSA Enrollment Guide to see if this plan is right for you!

Why should I participate?

If you're like most of us, you and your family will have health care expenses in the next 12 months. Your medical and dental plans will pay the majority of those expenses. But what about the part that isn't covered - like copayments?

The HFSA may help save tax dollars on these out-of-pocket costs. The money that you contribute into the HFSA comes out of your paycheck before taxes, and you do not pay taxes on the reimbursements you receive for qualified health care expenses.

What expenses are reimbursable?

- Items and services that you can deduct from your income tax, according to Internal Revenue Code 213
- Copayments, coinsurance and insurance deductibles for physicians, dentists, hospital and vision services
- Copayments for prescriptions, retail and mail order
- Prescription drugs not covered in the medical plan
- Orthodontia expenses
- Eye glasses, contact lenses and contact lens solution
- Corrective vision surgery (i.e. lasik)
- Over-the-counter medications, such as aspirin, cough and cold medicine, allergy and sinus medication, etc.

Since you never pay taxes on this money, you can save up to 35 percent in federal tax on the amount that you put into the HFSA. The amount you save will vary depending upon your individual income tax bracket.

OK – I'm curious. How does this work?

Enrollment is voluntary and you must re-enroll if you want to continue. Ask your HR liaison for the SMART Choice HFSA Enrollment Guide.

To access the HFSA plan documents visit www.houstontx.gov/hr/oe08/

SMART! Tip

Ask your benefits liaison for the HFSA guide which provides detailed information on how you can use this pretax benefit to lower your family's tax bill.

What do you spend?

In 2007, employees in the HMO spent about $215 in medical costs, and about $382 in prescription expenses.
That doesn't count over-the-counter items like aspirin, cold medicines or that stomach stuff. These items are also eligible.

SMART facts - at a glance

- **Minimum contribution:** $240 a year/$10 per pay period
- **Maximum contribution:** $2,000 a year/$83.33 per pay period
- **Plan year:** May through April
- **Incur claims:** May 1 through April 30
- **File claims:** Within 90 days beyond plan year, through July 29
- **Claim administrator:** FLEXONE
- **Minimum claim reimbursement:** $10

Dependent Care Reimbursement

Did you remember that this is another way you can save money? If you have qualifying expenses for dependent care, you can enroll in this plan in January. Watch for enrollment announcements in November.

Supplemental Insurance Plans

For active employees only

There are no changes in these plans. In fact, the rates are locked in for another year. That's right – no rate increase from 2001 to 2009. You may enroll in any or all of these three plans.

Hospital Indemnity plan

This plan pays a daily cash benefit while you or a covered dependent is hospitalized. The money is paid to the employee and may be used for all expenses, even if they are not medical expenses. These payments are in addition to your city medical plan.

Under this plan, pre-existing conditions are not covered for an injury or sickness that required medical advice or attention during the 12-month period before the effective date of coverage.

Accident/Disability plan

This plan provides a benefit if you or a covered dependent is injured or becomes disabled according to plan guidelines. The plan will pay a scheduled benefit on or off the job for:

- emergency room use and care
- hospital confinement
- disability income for off-the-job accidents - employee only
- accidental death
- follow-up visits to the doctor

When a covered accident occurs, benefits begin the first day treatment is rendered by a doctor or hospital. These benefit payments are in addition to benefits paid by your city medical plan.

Personal Cancer Protector plan

This plan provides supplemental insurance for you or a covered dependent diagnosed with cancer. Benefits are paid directly to you, not to a doctor or hospital.

You may use this benefit to pay for medical, travel and other expenses including, but not limited to:

- house or apartment payment
- utilities
- car payments
- copayments and deductibles
- necessary household help
- parking
- child care
- special equipment
- gasoline
- food and lodging

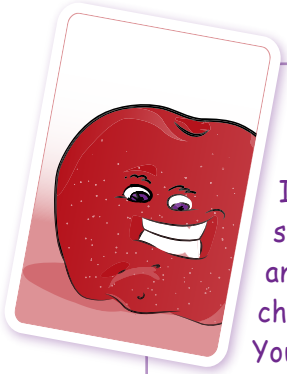
Supplemental Plan Checklist

- ☐ Brochures
- ☐ Enrollment forms

Rates and additional information

The rates for each plan are shown in the packet of information you will receive from your department human resources liaison. Benefits under the supplemental insurance plans will be effective May 1, 2008.

If you would like more information about the supplemental insurance plans, contact your department human resources liaison, or an AFLAC representative at (281) 440-1133 or (281) 440-3465.



Important Note

If you are enrolled in a supplemental insurance plan and don't want to make any changes, don't do anything. Your coverage will remain in effect through April 30, 2009. All deductions will be pretax, except for the disability plan.

New rates are effective May 1, 2008.

Active Employees' Bi-weekly Contributions (24 times per year)

	Non-tobacco user rates		Tobacco user rates	
HMO	**from**	**to**	**from**	**to**
Employee only	$15.65	$17.15	$28.15	$29.65
Employee + 1	$86.00	$94.28	$98.50	$106.78
Employee + 2 or more	$105.59	$115.76	$118.09	$128.26
PPO and Out-of-Area				
Employee only	$92.77	$122.72	$105.27	$135.22
Employee + 1	$271.92	$348.85	$284.42	$361.35
Employee + 2 or more	$350.07	$450.50	$362.57	$463.00

Retirees Under 65 Monthly Contributions

HMO	**from**	**to**	**from**	**to**
Retiree only	$136.22	$149.34	$161.22	$174.34
Retiree + 1	$401.98	$440.68	$426.98	$465.68
Retiree + 2 or more	$626.86	$687.22	$651.86	$712.22
PPO and Out-of-Area				
Retiree only	$458.02	$557.04	$483.02	$582.04
Retiree + 1	$1,178.10	$1,423.68	$1,203.10	$1,448.68
Retiree + 2 or more	$1,647.88	$1,979.96	$1,672.88	$2,004.96

Retirees Over 65 Monthly Contributions

HMO	**from**	**to**	**from**	**to**
Retirees over 65 without Medicare				
Retiree only	$421.38	$461.96	$446.38	$486.96
Retiree + 1	$884.90	$970.12	$909.90	$995.12
Retiree + 2 or more	$1,516.98	$1,663.06	$1,541.98	$1,688.06
Retirees over 65 with Medicare				
Retiree w/Medicare	$131.44	$144.10	$156.44	$169.10
Retiree + 1 (1 w/Medicare)	$262.96	$288.28	$287.96	$313.28
Retiree + 1 (2 w/Medicare)	$256.36	$281.04	$281.36	$306.04
Retiree + 2 or more (1 w/Medicare)	$447.00	$490.04	$472.00	$515.04
Retiree + 2 or more (2 w/Medicare)	$407.56	$446.80	$432.56	$471.80
PPO and Out-of-Area	**from**	**to**	**from**	**to**
Retirees over 65 without Medicare				
Retiree only	$621.80	$786.40	$646.80	$811.40
Retiree + 1	$1,305.74	$1,667.76	$1,330.74	$1,692.76
Retiree + 2 or more	$1,617.64	$2,075.84	$1,642.64	$2,100.84
Retirees over 65 with Medicare				
Retiree w/Medicare	$399.60	$498.86	$424.60	$523.86
Retiree + 1 (1 w/Medicare)	$1,049.76	$1,049.76	$1,074.76	$1,074.76
Retiree + 1 (2 w/Medicare)	$440.72	$687.30	$465.72	$712.30
Retiree + 2 or more (1 w/Medicare)	$1,140.24	$1,404.44	$1,165.24	$1,429.44
Retiree + 2 or more (2 w/Medicare)	$1,047.30	$1,271.22	$1,072.30	$1,296.22

Prescription Plan Highlights

Congratulations

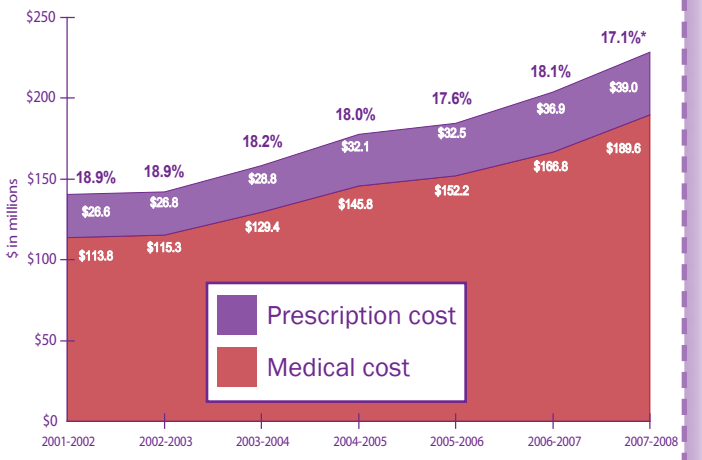
Because you've managed your prescription drug costs so well, you've earned a reward: Prescription benefits will stay the same for this plan year.

You've become knowledgeable consumers of prescriptions, asking yourself the important questions to save you and the city money:

- Is this medication required for my condition? If the condition will get better on its own, you're staying away from costly prescriptions.
- Is this the best medication for my condition? You're diligent about checking if there is something that would cure the problem faster and cheaper.
- Would mail order be less expensive? If you need to take the medicine for 90 days or more, you know it is.
- Is there a generic medication available? You're aware that generic drugs are copies of brand-name drugs, identical in dosage, safety, strength, quality, performance and intended use. But, because manufacturers don't have the investment cost of developing a new drug, they're able to pass those savings on to you.

The game's not over yet, though. Because prescription drug costs keep rising, it's as important as ever to remain vigilant about finding savings. Remember, when it comes to prescription drugs, cheaper doesn't mean weaker.

Prescriptions as a percent of total claims**



* Estimated
** Excludes data from MA plans.

As of 10/31/2007

Prescription plan features

This is a **three-tier prescription** plan, with different copayments in each tier. Drugs are assigned to the tiers based on the BCBSTX formulary, which can change annually, usually in May.

Prescription coverage		
HMO and PPO at participating pharmacy		
Tier	**Retail pharmacy** 30-day supply	**Mail-order** 90-day supply
Generic	$10	$20
Preferred	$30	$60
Non preferred	$45	$90
PPO and OOA at nonparticipating pharmacy		
All	50% after $20 copayment	not available

To find out which drugs are in each of the three tiers, go to **www.bcbstx.com**. If the cost of the prescription is less than the copayment, you pay the lower amount.

The **step therapy feature** requires your doctor to consider alternative medication before prescribing the higher-cost medications in five prescription drug categories. The five categories are below:

- COX-2 Inhibitors (Celebrex)
- Leukotrienes for Asthma (Accolate, Singulair)
- Rheumatoid arthritis drugs (Enbrel, Humira, Kineret)
- ACE Inhibitors (Accupril, Mavik, Altace, Aceon)
- Angiotensin II receptor blockers (Avapro, Atacand, Cozaar, Diovan)

New drugs could be added periodically.

Certain drugs are limited to a specific quantity over 30 or 90 days. This is called **quantity versus time** and applies to retail and mail order prescriptions, including all nasal inhalers, migraine medications, asthma inhalers, pain management medicines, proton pump inhibitors, and others. When more medication is necessary, BCBSTX must approve the higher quantity. To find out what drugs are subject to quantity limits, visit www.bcbstx.com or call 800-521-2227.

Through BCBSTX's **mail order pharmacy**, Prime Therapeutics, you can order a 90-day supply for the price of a 60-day supply.

Dental indemnity plan

A dental indemnity plan is a traditional plan that lets you receive a comprehensive range of dental services from the provider of your choice anywhere in the United States. You pay a percentage of charges for certain services and file a claim for reimbursement.

To use the plan:

- Make an appointment with the dentist of your choice.
- If the treatment will cost more than $200, get a cost estimate.
- Pay the dentist. Some dentists require patients to pay only their portion.
- File a claim for reimbursement within 90 days. Some dentists will file your claim for you.

The chart on page 13 shows some services provided under the dental indemnity and DHMO plans. For a complete list of services provided under this plan, refer to the City of Houston Dental Indemnity Plan brochure.

In-network preferred dentist option

If you are enrolled in the dental indemnity plan, you can reduce your out-of-pocket costs by using a preferred dentist. If you receive care from a preferred dentist or a network of dental providers, you will receive a discount on your dental services and have more money in your pocket.

As you can see in the chart below, if you use a preferred dentist, you will realize a considerable savings. The more costly the dental work, such as bridges or dentures, the more savings you will realize. Also, because all fees are reduced, you will receive more services before you reach the $1,500 annual maximum benefit.

The city's In-network Preferred Dentist Option brochure provides information about this feature as well as a list of preferred dentists in the network. Contact the benefits division for a brochure.

Example of savings using a preferred dentist

Plan	Usual cost	50 percent coinsurance
Out-of-network	$875	$437.50
In-network	$701	$350.50
Your savings		*$87.00*

Dental Materials Checklist

- ☐ DHMO brochure
- ☐ Dental Indemnity brochure
- ☐ In-network dentist brochure
- ☐ Change/Election forms

Important Note

With the dental indemnity plan, you pay for services you receive at the time of your appointment and file a claim for reimbursement. If your dentist files the claim, you may be asked to pay only the portion the plan will not pay. You can get a claim form from the benefits division.

You must submit your claim within 90 days after the date of service. Reimbursement is made by mail, usually within 10 work days.

To check the status of a claim, call (866) 605 - 2599.

Mail your claim forms to:

United HealthCare, Inc.
1445 North Loop West, Suite 500
Houston, Texas 77008

Counties in the DHMO service area

Anderson, Bowie, Brazoria, Brazos, Brown, Carson, Chambers, Collin, Dallas, Deaf Smith, Delta, Denton, Ellis, Fannin, Fort Bend, Galveston, Gray, Grayson, Grimes, Harris, Harrison, Hood, Hopkins, Hunt, Hutchinson, Jefferson, Johnson, Kaufman, Lamar, Liberty, Montgomery, Moore, Nacogdoches, Orange, Parker, Potter, Randall, Rockwall, Tarrant, Walker, Waller

Web site

Here's easy access to network dentists, claim information, dental definitions, brushing tips for kids, and other dental education - **www.myuhdental.com**.

Dental Plan Highlights

Dental highlights

No news is good news. Your dental rates and benefits remain the same for May 2008. In fact, they won't change again for another year — until May 1, 2009.

United Healthcare, Inc. provides the dental indemnity plan and National Pacific Dental provides the DHMO plan.

See the charts below for contributions and a comparison of plan features.

Dental contributions

DHMO contributions	Employee bi-weekly cost	Retiree monthly cost
Self only	$4.33	$8.66
Self + one	$9.33	$18.66
Self + two or more	$13.20	$26.40
Dental Indemnity Plan contributions		
Self only	$12.50	$25.00
Self + one	$28.91	$57.82
Self + two or more	$39.41	$78.82

DHMO

A dental health maintenance organization is a network of dentists, like an HMO, that offers a comprehensive range of dental services for fixed copayments. You choose a primary care dentist who coordinates your care and refers you to specialists. You must live in the service area to enroll.

Features of the DHMO include:

- No maximum annual limit on dental services,
- No deductibles,
- No claim forms to complete for most procedures,
- A fixed copayment for dental services, and
- A network that includes dentists and orthodontists.

SMART! Tip

Sign-up for the Healthcare Flexible Spending Account to save even more on your dental copayments. See page 16 for more information.

Comparison of Dental Indemnity and DHMO features

Plan Features	DHMO	Dental Indemnity
Preventive Services	**Sample copayments**	
Cleaning and oral examinations, bitewing X-rays	Preventive services - $0	The plan pays 100 percent of services up to usual and customary limits. $0 deductible
Basic Services		
Extractions, root canals, oral surgery, restorative services (excluding gold fillings) and periodontal scaling	Extraction, Coronal Remnants - $9 Periodontal Scaling - $14-24 Root Canal Therapy, Molar - $162	After you pay the annual deductible, the plan will pay 80 percent of services, up to usual and customary limits.
Major Services		
Initial fixed bridgework, crowns and dentures, replacement of bridgework	Crown - Titanium - $210 Complete Denture, Maxillary - $260 Immediate Denture, Maxillary - $270	After you pay the annual deductible, the plan will pay 50 percent of services, up to usual and customary limits.
Orthodontic Services		
Covered services up to two years	Adult, 24-month Case - $2,000 Adolescent, 24-month Case - $1,800 Interceptive Ortho Service - $1,100 (Primary and Transition Dentition)	After you pay the annual deductible, the plan will pay 50 percent of services, up to usual and customary limits. The lifetime maximum benefit is $1,000 per individual.
Annual Maximum Benefit	No annual maximum benefit	$1,500 per individual
Annual Deductible	No annual deductible	$50 for each individual / $150 family
Referrals for Specialty Care	PCD must refer patient to specialist	Not required
To Receive Reimbursement	Filing a claim is not required	Complete and submit a claim form

For a list of DHMO benefits and copayments visit www.houstontx.gov/hr/oe08/

The **mandatory generic** feature calls for filling your prescription with a generic drug if one is available. Remember, generic drugs are copies of brand-name drugs, identical in dosage, safety, strength, quality, performance and intended use. If you still prefer the brand-name drug when a generic is available, you will have to pay extra.

Example of generic drug savings

	Brand-name	Generic	Savings
Treatment Usual dose	Drug Name Cost	Drug Name Cost	30-day supply
Diabetes 500 mg tab	Glucophage **$67.99**	Metformin **$18.99**	**$49.00**
High cholesterol 20 mg tablet	Zocor **$154.99**	Simvastatin **$50.59**	**$104.40**
Allergy symptoms 60 mg tablet	Allegra **$98.59**	Fexofenadine **$40.39**	**$58.20**
High cholesterol 40 mg tablet	Pravachol **$179.99**	Pravastatin **$48.29**	**$131.70**

How mandatory generic works

If your doctor prescribes a generic drug but you purchase a brand prescription, you will pay more for your medicine. Your copayment will be the total of the generic copayment plus the difference between the cost of the brand and the generic drug.

Doctor prescribes generic Fluoxetine (20 mg)	$16.39
You purchase brand-name Prozac (20 mg)	$174.99
Difference in price	$158.60
Your cost = price difference + $10 generic copayment	**$168.60**

Mail-order sounds easy; sign me up!

To switch your long-term prescriptions to Prime Therapeutics, visit **www.houstontx.gov/oe08/mail.htm** or get a mail order form from your human resources liaison.

You've done a good job!

Talk about a winning combination. Saving yourself and the city money on prescriptions is simple and convenient. Generics offer the same benefits as name-brand drugs at a lower cost, while mail order drugs offer even lower prices and front-door delivery. City employees and retirees understand this, and you are taking advantage of the discounts. Here's how you score compared to BlueCross BlueShield's other customers:

Generic usage scorecard

	COH	BCBS clients
Generic utilization: Percent of drugs prescribed that are generic	63 %	57 %
Generic substitution: Percent of generics used when a generic is available	96 %	95 %

Mail-order usage scorecard

Percent of all prescriptions that are ordered via mail-order	16%	4%

Date: October 31, 2007

A prescription for savings

Want to save even more on your prescriptions? Wal-Mart, Sam's Club, Target, Randalls and Kroger each offer more than 300 generic medications for just $4 and HEB offers generic medications for $5. That's less than half of your prescription drug copayment, saving you $72 a year per discounted medication. Discounted drugs include those for asthma, depression, diabetes, heart disease, and glaucoma among many others.

To view the list of medications available for $4 or $5, visit the following Web sites:

- **www.walmart.com/pharmacy** for Wal-Mart and Sam's Club
- **www.target.com/pharmacy**
- **www.kroger.com/generic**
- **www.randalls.com**
- **www.heb.com/pharmacy**

*Giant Eagle stores also offer $4 generics in Ohio, Maryland, Pennsylvania and West Virginia.

Health Plan Highlights

Prescription Checklist

What should you be asking your doctor about prescriptions? Clip out this checklist and on your next doctor's visit, be prepared.

- ☐ Gather together, place in a bag and take with you anything you're taking, including:
  - ☐ prescription drugs
    _____
    _____
    _____
  - ☐ over-the-counter medication
    _____
    _____
    _____
  - ☐ vitamin supplements
    _____
    _____
    _____
  - ☐ herbal remedies
    _____
    _____
    _____
- ☐ Write a list of questions you want to ask your doctor.
  _____
  _____
  _____
- ☐ Make a list of medications you need to ask about. Find out if there really are special benefits, which you may have seen advertised.
  _____
  _____
  _____
- ☐ Ask about possible side effects.
- ☐ Ask if an antibiotic is really necessary. If it is, request that it be a "narrow spectrum" type for your specific need.
- ☐ Bring a copy of your three-tiered drug list.
- ☐ Ask if there is a generic equivalent of your prescribed brand-name drug.
- ☐ Be sure to have your HMO Blue Texas ID card with you.

Top 10 prescriptions for employees and retirees

Paying the retail cost for prescription drugs is expensive. But you are spared that expense by the city's three-tier prescription drug benefit – especially if you use generic drugs.

It's easy to find what tier your prescriptions are in. Check the chart below to see if your prescription is also one of the top 10 medicines. Then, compare your cost with the retail cost and see how much your plan saves you in out-of-pocket expenses. To see the entire list of preferred drugs, go to **www.bcbstx.com**, pharmacy option.

Top 10 prescriptions by amount spent

Drug Treatment/Usual dosage	$10 Generic	$30 Preferred	$45 Nonpreferred	Retail cost 30-day Supply
1. **Nexium** *GERD; 40 mg capsule*		X		$168.99
2. **Lipitor** *Cholesterol; 20 mg tab*			X	$134.99
3. **Enbrel*** *Arthritis; 50 mg/ml injection*		X		$2,172.73
4. **Actos** *Diabetes; 30 mg tab*		X		$207.99
5. **Prevacid** *GERD; 15 mg capsule*			X	$172.99
6. **Diovan*** *High Blood Pressure; 80/12.5 mg tab*		X		$81.59
7. **Tracleer** *Primary pulmonary hypertension 125 mg tab*		X		$4,109.48
8. **Topamax** *Anti-convulsant; 100 mg tab*		X		$384.99
9. **Valtrex** *Herpes virus; 500 mg cap*		X		$194.99
10. **Protonix** *GERD; 40 mg tab*		X		$128.99

Source: Local retail pharmacy. Date: October 31, 2007.

**Step therapy drug.*

As always, if the retail cost of the prescription is less than the copayment, you pay the lower amount.

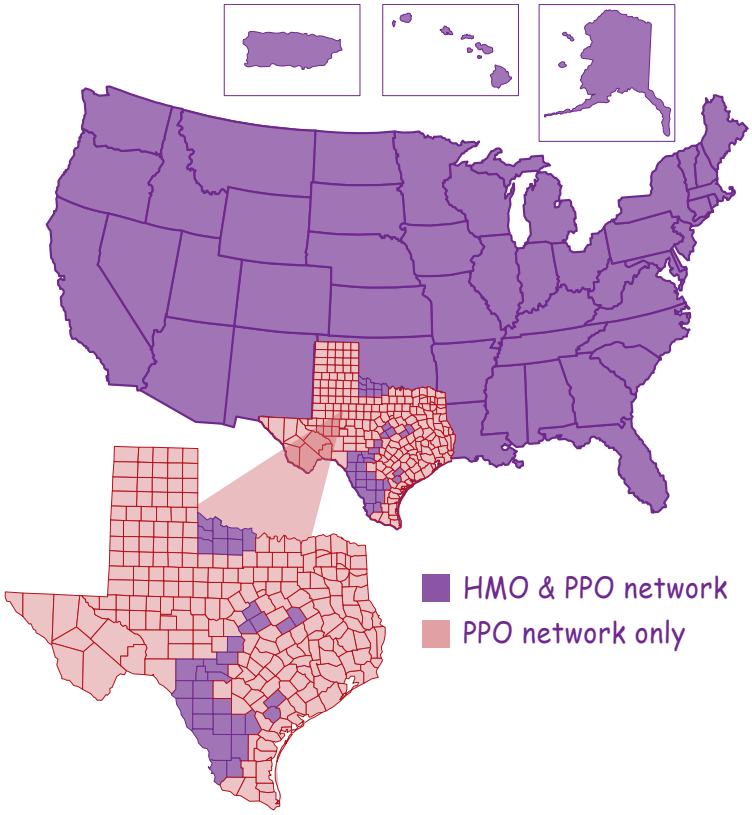
As of October 2007

Important Note

For medical and dental plans, only new enrollees will receive new ID cards for May 1, 2008. Your current ID card has no expiration. If you need additional or replacement ID cards, call HMO Blue Texas at (713) 837-9377 or visit **www.bcbstx.com.**

Service Area

The map below shows the broad coverage of the service area for HMO and PPO plans. The HMO includes more than 200 counties in Texas and the PPO includes every state, plus Puerto Rico. Your ID card is accepted by additional doctors and hospitals and a larger retail pharmacy network.



HMO service area

The HMO service area is as big as the state of Texas, except for these 34 counties — Archer, Bandera, Baylor, Clay, Coryell, DeWitt, Dimmit, Duval, Edwards, Falls, Foard, Frio, Gillespie, Goliad, Hamilton, Hardeman, Jim Hogg, Kerr, Kinney, Knox, La Salle, Lampasas, Limestone, Live Oak, Llano, McMullen, Maverick, Real, Uvalde, Webb, Wichita, Wilbarger, Zapata, Zavala.

PPO service area

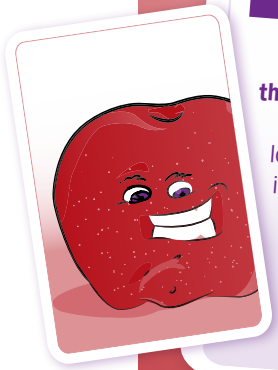
The BlueChoice PPO network is as big as America itself. That means employees and retirees under the plan can find contracted providers in every state, plus Puerto Rico.

Winning Tip

The BlueCard program provides temporary coverage if you or a dependent visits or resides outside the HMO and PPO service area. There are HMO networks in 35 states that honor the BlueCard. Your ID card has a little suitcase logo that denotes this benefit. Benefits are available only through network providers in that location. Call the number on the back of your ID card to learn more about this benefit.

Winning Tip

For a provider directory with the complete list of HMO & PPO doctors and medical providers in the network, visit the HMO Blue Texas Web site at **www.hmobluetexas.com** or **www.bcbstx.com**. You may also request a directory from your HR Liaison.



Apple A. Day Card

Wear your seatbelt. **Drive forward three squares for buckling up.** Statistics show that seatbelts add to longevity and help alleviate potential injuries in car wrecks.

Apple A. Day's thought for the day: Buckle up for safety.