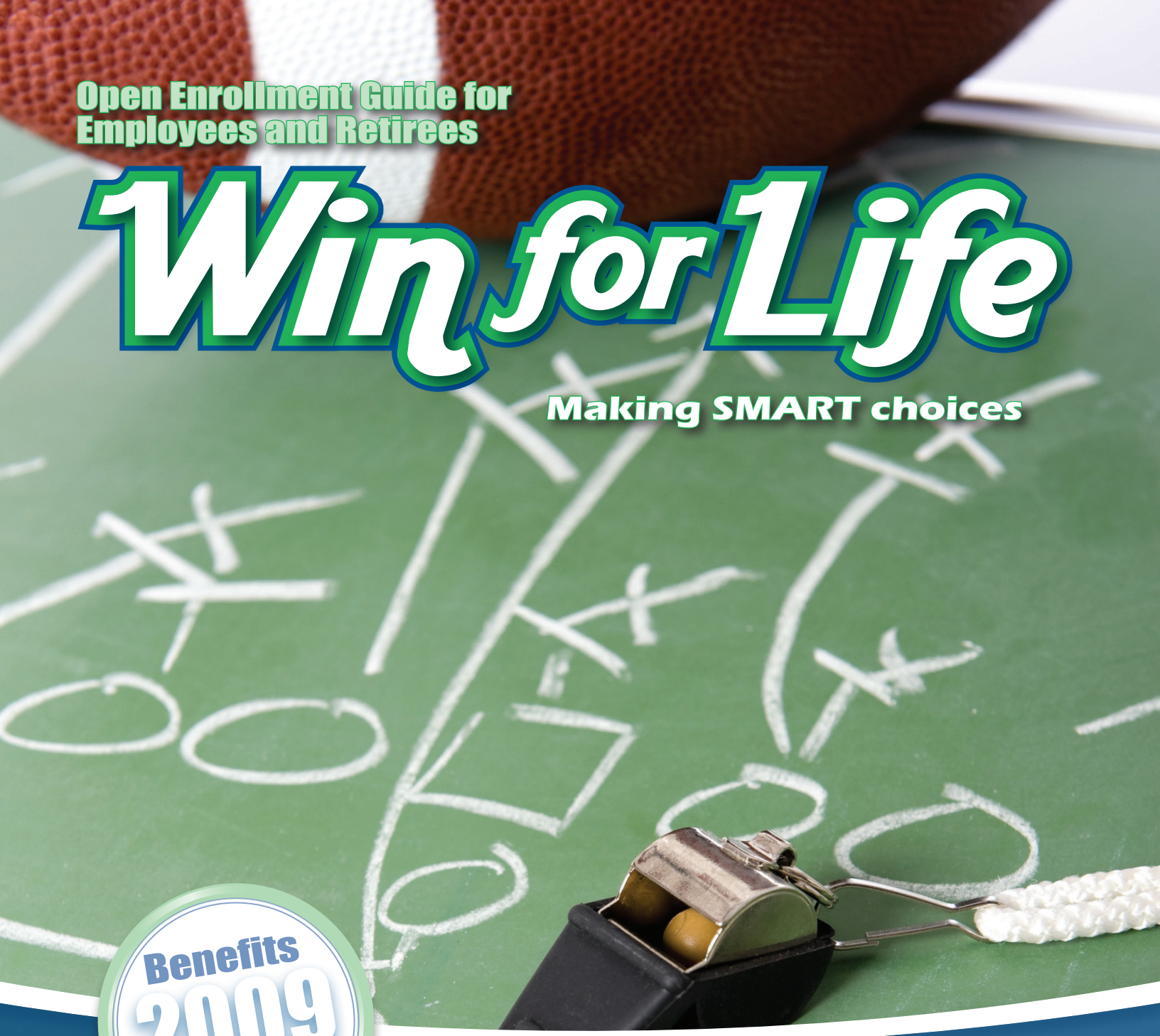
Open Enrollment Guide for Employees and Retirees

Win for Life

Making SMART choices



Benefits 2009 Preview

1 2009 Open Enrollment

A message from the coach

Dear employees and retirees,

Health-care costs continue to rise, forcing some tough decisions on employers. One of the toughest competitions I've encountered is preserving the high-quality, affordable benefits plans that city employees are used to and deserve. It's also one of my top priorities even in these tough economic times. Once again, we've been able to do that this year with only a few new plays in the plan. Read the details on page 4 of this playbook. The results, though, are that we are able to keep members' rate increases minimal -- less than a dollar a paycheck for employee-only HMO coverage, and less than $7 a paycheck for a family in the HMO plan.

The city's medical-plan costs will increase from $273 million in FY09 to $293 million in FY10. To keep on track with this large expense and sustain the plan's current benefit levels, the city will share the cost increase with you. The city will maintain the 79 percent city, 21 percent employee split for active employees in HMO plan. Overall, the city will pay 73 percent of the health-care coverage costs. You can find those new rates on page 8. As you can see from page 7, the premiums you pay are still very reasonable and much lower than employees elsewhere are paying. Your dental benefits will remain the same, but the rates will increase slightly, as we told you last year.

If you have questions about your benefits, please see your HR liaison or attend an open-enrollment meeting. You can obtain a meeting schedule at www.houstonhumanresources.org.

We've been able to keep premiums lower because you are using your health-care dollars wisely. If you continue to do that and we 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,

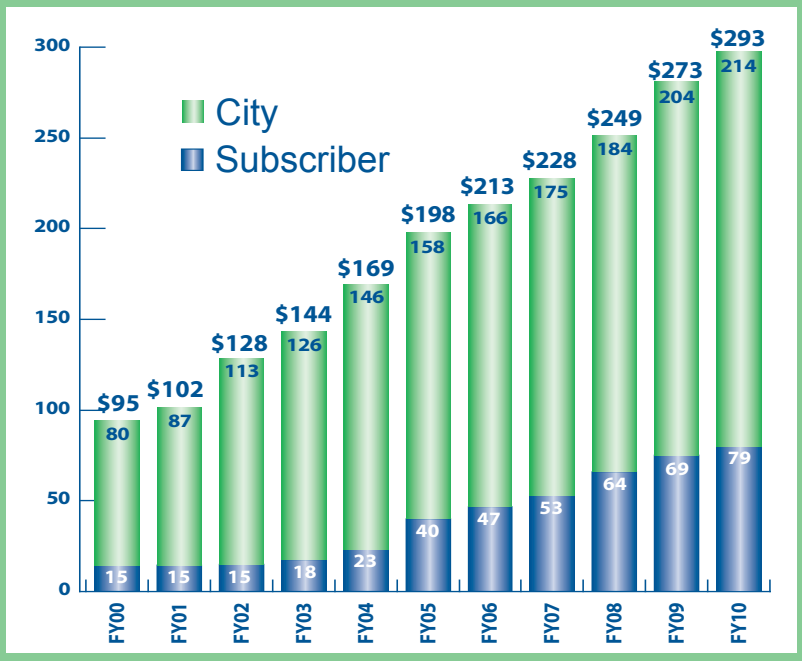
Bill White

Mayor

Insider's 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, 2010. Be sure to note the new contribution rates and other changes on page 4.

Medical plan expenditures in millions



Total fiscal-year premiums (including all fees) for all medical plans

The starting line up:

Here are the plans you may choose during the enrollment period.

Health plans

- HMO
- PPO
- Plan A (for grandfathered retirees)
- Three Medicare Advantage plans for Medicare-covered participants

Dental plans

- Dental HMO
- Dental indemnity

Supplemental insurance plans

- Cancer
- Hospital
- Accident/disability

Flexible-spending accounts

- Health care
- Dependent care

On the bench:

Other benefits offered year-round

- Basic life insurance – one times salary, paid by the city
- Voluntary life insurance – up to four times salary, employee-paid
- Time off – holidays, vacation, sick and wellness leave, and personal days for full-time employees and paid time-off for police officers
- Long-term disability – paid by the city, for eligible full-time municipal employees and firefighters
- Pension – defined benefit plan with unique plans for civilians, police and fire classified employees
- 457 pretax deferred-compensation savings plan
- Subsidized transportation benefits

Who's in the game?

Who	HMO	PPO	Total
Employees	20,378	487	20,865
Retirees	6,871	431	7,302
Dependents	36,523	418	36,941
MA enrollees			2,220
Total	**63,772**	**1,336**	**65,108**

A few new plays for 2009

- Two new medication categories have been added to the step-therapy program. Plan members taking brand-name Proton Pump Inhibitors, such as Nexium, will need to start at the first step, a $10 generic. Plan members who start taking cholesterol-lowering statins will be required to try a $10 generic before moving on to more-expensive drugs. See page 4 for more information.
- Specialty drugs are now available to members exclusively through the Triessent Specialty Drug Program. Members will pay $30 or $45 for a 30-day supply for these high-priced medications. See page 4 for more information.
- As of May 1, 2009, retirees may not add dependents to their medical or dental plan. Dependents already covered may stay on your plan until they become ineligible. See page 3 for details.
- Your contributions to the medical plan will change. The contribution strategy for retirees under age 65 will change. See pages 7-8 for details.
- Dental rates have increased slightly. See pages 13-14 for details.

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3 Health plan highlights

Retiree dependent coverage

Check this out!

Effective May 1, rules will change for retirees covering dependents under the medical plans.

- You may keep coverage on eligible dependents already covered under one of the city's medical plans. Dependents may stay on your plan until they become ineligible according to plan rules: they turn age 25, marry, gain primary coverage under another plan, are no longer your dependent, join the armed forces, etc.
- After you retire, you may not add new dependents to the medical or dental plan.
- If you are already retired, you may keep coverage on eligible dependents until they become ineligible, but you cannot add new dependents.
- The new rule applies to dependents you acquire after May 1, 2009. Dependent includes the following: spouse, natural born or adopted children, grandchildren, children under age 25 who return to dependency on a retiree, children over age 25 who become disabled and dependent on a retiree, etc.
- If you drop coverage on a dependent, coverage may not be reinstated.

Health plan preview

Here's your health plan scouting report — you have two options for your comprehensive medical plans, HMO and PPO. Both deliver championship care with predictable, budget-friendly costs.

The HMO plan requires that all your care be directed by your primary care physician. You must use network providers, except in case of emergency or referral by your network doctor.

The PPO plan offers more flexibility, more doctors, no PCP requirement and the option to go out-of-network. But you pay more for the added flexibility, in your contribution and at the time of service.

For a tale of the tape to help you decide between these two plans, see pages 5 and 6.

Type of services

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

- If the service is performed by the PCP in the office, the lower copayment will apply, $20 in the HMO and $30 in the PPO in-network.
- 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 in-network.
- Most services such as home visits, family planning, infertility treatment, physical therapy, and similar services are "specialist services," and you will pay the higher copayment. Note: artificial insemination requires a 50 percent copayment of usual and customary for each procedure.

To see a comparison of plan features and your out-of-pocket costs, see page 5.

Insider's tip

The HMO and PPO plans provide prescription coverage at a low-cost to you. Turn to pages 11-12 for information.

What's new

Not much. There are a few new features to prescription benefits, contribution strategies for retirees under age 65 and a new dependent eligibility rule for employees who retire after May 1.

1. Two new step-therapy categories to help you win over high prices

As of May 1, two additional categories of medications are being added to step therapy. This gives you a chance to save money by requiring your doctor to prescribe generic versions of the medicine before moving on to more-expensive brand-name drugs. Remember, generics are copies of brand-name drugs, identical in dosage, safety, strength, quality, performance and intended use. And, they only cost you $10 for a 30-day supply at your local pharmacy, or $20 for a 90-day supply through Prime Therapeutics mail order.

Proton pump inhibitors for GERD, heartburn or stomach ulcers: If you take a proton pump inhibitor, such as Nexium, Prevacid or Protonix, your doctor must prescribe a generic PPI before you can receive a brand-name. **This is the case even if you are currently taking a PPI. This will begin with the first refill you get after May 1.** If the generic fails to sufficiently treat your condition, your doctor can request authorization to step you up to another generic or brand-name PPI.

If you are one of the more than 4,400 members taking a proton pump inhibitor, be sure to read here for information on a change that affects you.

Statins for high cholesterol: Members who begin taking a statin will be required to start with a generic statin. If the generic fails to sufficiently lower your cholesterol, your doctor can step you up to a preferred brand-name statin.

Members who currently take a brand-name statin, such as Lipitor or Vytorin, are grandfathered and may continue to take that medication. BCBSTX can change the tier in which any brand-name drug appears, increasing or decreasing your copayment. For a complete list of step-therapy drug categories, see page 11.

2. Triessent will now be your one-stop specialty drug pharmacy

If you take a high-cost specialty drug, such as Enbrel or Tracleer, you will soon receive a letter from Triessent asking that you call and sign up for the specialty-drug program. Once you have signed up, Triessent each month will send a 30-day supply of the specialty medication to your home or your doctor's office. The 30-day supply will cost you just $30 or $45. By sending you a 30-day supply, Triessent minimizes waste from discontinued therapy or dosage changes. A representative will call you to coordinate refills.

If you do not order your specialty drugs through Triessent, you will be able to get just one refill at your local retail pharmacy. After that, refill requests will be denied. Call 888-216-6710 to sign up for the program.

Specialty drugs are used to treat many different ailments, including cancer, cystic fibrosis, hemophilia, HIV, Hepatitis C, and multiple sclerosis. These drugs can cost thousands of dollars a month for a single prescription.

Triessent, a specialty pharmacy provider that manages specialty drug programs and services for the HMO and PPO, allows a more cost-effective purchase of these expensive medications. Go to www.bcbstx.com for a complete list.

3. The contribution strategy will change for retirees under age 65

Plan usage shows that retirees under age 65 incur greater claims costs than active employees and retirees with Medicare.

In order to offset the disparity, the aggregate contribution percentage for retirees under age 65 will increase from 33 to 38 percent. See pages 7-8 for details.

4. Adding dependents for employees who retire after May 1

Employees who retire on or after May 1 may cover dependents who are covered the day before they retire, but may not add dependents to their medical or dental plan on or after May 1, 2009. See page 7 for details.

Mail-order prescriptions and PPIs

If you currently have a mail-order prescription for a brand-name proton pump inhibitor with Prime Therapeutics, you must ask your doctor for a new prescription. Otherwise, you will be charged for the full cost of the prescription plus the cost of the generic minus the generic copayment of $10. See "How mandatory generic works" on page 11 for an example.

5 Health plan highlights

Health plan features at-a-glance

Plan feature		What you pay		
		HMO	PPO in-network	PPO Out-of-network
Deductible (Individual/Family)		N/A	$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		$100	20%	20%
Outpatient surgery		$200	20%	40%
Annual maximum copayment/coinsurance				
Individual		$1,500	$3,000	$5,000
Family		$3,000	$6,000	$10,000
Prescriptions participating pharmacy copayment*				
Retail pharmacy (30-day supply)	Generic	$10	$10	$10
	Preferred brand	$30	$30	$30
	Non-preferred brand	$45	$45	$45
Mail-order pharmacy (90-day supply)	Generic	$20	$20	$20
	Preferred brand	$60	$60	$60
	Non-preferred brand	$90	$90	$90

*Generics are mandatory if available.

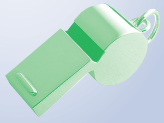
Doctors in the HMO and PPO

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

* Pediatricians/specialty care providers participating in the HMO network.
** Physicians may be available through independent contracts instead of through the IPA.
***Available through referral only.
****Kelsey-Seybold no longer provides services to Medicare-covered PPO members. See page 10 for more information.

Insider's tip

To stay at the top of your game, it's important that you stay in shape. See page 18 for some BlueCross BlueShield programs that can help you do that.



Service areas

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

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, LaSalle, Lampasas, Limestone, Live Oak, Llano, McMullen, Maverick, Real, Uvalde, Webb, Wichita, Wilbarger, Zapata, Zavala.

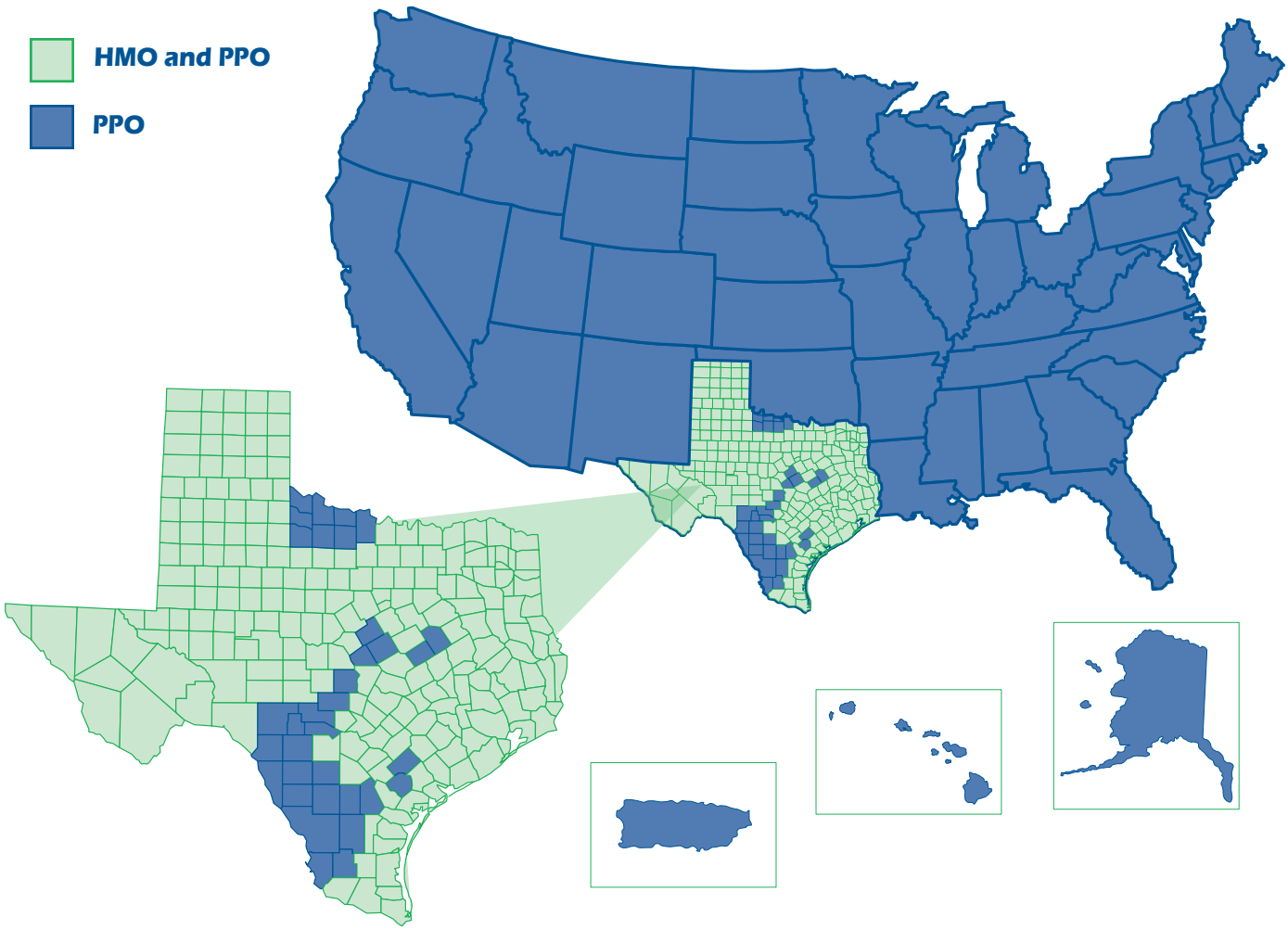
PPO

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.

Enrollment Options

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

*If you live in the plan's service area.
**The out-of-area plan is only available to employees/retirees who live outside the PPO/HMO service area. See a list of zip codes at www.houstontx.gov/hr/oe09.



1 Contributions

The team budget

Health care, like sports, is a big-bucks world. Costs nationwide keep going up. Each year, the city and its heavy hitters struggle to achieve the right balance of benefits and contributions. To keep the same top-of-the-order benefits employees, retirees and dependents enjoy, the city and plan members must share the increased costs.

In FY10, the city expects to spend $293 million for health care, up from $273 million last year. HMO rates are going up 5.73 percent and PPO rates are going up 3.9 percent.

The city contributes 79 percent for active employees and 73 percent for active and retired employees combined. Starting May 1, the contribution strategy will change based on employees' and retirees' use of the plans.

Plan utilization shows that between March 2005 and September 2008, medical claims costs for retirees under age 65 were, on average, 42 percent higher than for each of the other two groups. Because Medicare doesn't alleviate the medical costs of those under-age-65 retirees, the cost burden falls to the city and the retiree.

Over the next three years, retirees under age 65 will pay an increased percentage, from 33 percent to 38 percent on May 1, 2009 and to 48 percent by May 2011 in two steps. This increase is less than what retired employees under age 65 are paying at other companies that still offer retiree benefits.

This will put the city in a much better position to offer this benefit to retirees for years to come. And when you turn 65, the Medicare Advantage plans offer tremendous cost savings for retirees.

The contribution ratios for the other groups will remain the same - 21 percent for active employees in the HMO and 29 percent for retirees on Medicare in the HMO.

Here's what that means to you:

Active employees:

- HMO rates will increase 5.73 percent.
- PPO rates will increase about 3 percent.

Retirees under age 65:

- Retirees under age 65 contribute a greater portion than employees and other retirees because claims for that group are higher.
- HMO rates will increase 24 percent.
- PPO rates will increase about 4 to 6 percent.

Retirees on Medicare:

- HMO rates will increase about 8 to 9 percent.
- PPO rates will increase about 2 to 6 percent.
- Medicare Advantage plans will not increase. Rates are still $9.76, $18 or $61 per person, per month. Ask for a guide to these plans so you can save on premiums

Spotlight: PPO annual deductible

The PPO plan has a calendar-year in-network deductible of $200 for individuals and $600 for families. The family 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.

Monthly rate comparison

Company (Predominant Plan)	Tier	Employee's contribution	Employer's contribution
City of Houston (HMO)	EE only	$36	$310
	EE + family	$245	$852
Rice University (HMO)	EE only	$61	$321
	EE + family	$391	$791
HISD (Consumer Plan)	EE only	$278	$188
	EE + family	$304	$858
Harris County (PPO)	EE only	$0	$462
	EE + family	$367	$829
Private Local (PPO)	EE only	$104	$314
	EE + family	$336	$882

Source: City of Houston annual health benefits survey, January 2009. City of Houston data effective 5/1/09. Other participants' data valid YTD 2008. Amounts rounded to whole dollars.

New rates are effective May 1, 2009

Active employees' bi-weekly contributions (24 times per year)

	Non-tobacco user		Tobacco user	
HMO	**From**	**To**	**From**	**To**
Employee Only	$17.15	$18.13	$29.65	$30.63
Employee + 1	$94.28	$99.68	$106.78	$112.18
Employee + 2 or more	$115.76	$122.39	$128.26	$134.89
PPO and Out-of-Area	**From**	**To**	**From**	**To**
Employee Only	$122.72	$126.21	$135.22	$138.71
Employee + 1	$348.85	$360.28	$361.35	$372.78
Employee + 2 or more	$450.50	$465.06	$463.00	$477.56

Retirees under 65 monthly contributions

HMO	**From**	**To**	**From**	**To**
Retiree Only	$149.34	$185.36	$174.34	$210.36
Retiree + 1	$440.68	$546.98	$465.68	$571.98
Retiree + 2 or more	$687.22	$853.00	$712.22	$878.00
PPO and Out-of-Area	**From**	**To**	**From**	**To**
Retiree Only	$557.04	$580.40	$582.04	$605.40
Retiree + 1	$1,423.68	$1,499.42	$1,448.68	$1,524.42
Retiree + 2 or more	$1,979.96	$2,105.54	$2,004.96	$2,130.54

Retirees over 65 monthly contributions

HMO	**From**	**To**	**From**	**To**
Retirees over 65 without Medicare				
Retiree Only	$461.96	$503.62	$486.96	$528.62
Retiree + 1	$970.12	$1,057.62	$995.12	$1,082.62
Retiree + 2 or more	$1,663.06	$1,813.04	$1,688.06	$1,838.04
Retirees over 65 with Medicare				
Retiree Only with Medicare	$144.10	$166.18	$169.10	$191.18
Retiree + 1 (1 w/ Medicare)	$288.28	$332.46	$313.28	$357.46
Retiree + 1 (2 w/ Medicare)	$281.04	$324.12	$306.04	$349.12
Retiree + 2 or more (1 w/ Medicare)	$490.04	$565.14	$515.04	$590.14
Retiree + 2 or more (2 w/ Medicare)	$446.80	$515.28	$471.80	$540.28
PPO and Out-of-Area	**From**	**To**	**From**	**To**
Retirees over 65 without Medicare				
Retiree Only	$786.40	$816.36	$811.40	$841.36
Retiree + 1	$1,667.76	$1,731.38	$1,692.76	$1,756.38
Retiree + 2 or more	$2,075.84	$2,154.98	$2,100.84	$2,179.98
Retirees over 65 with Medicare				
Retiree Only with Medicare	$498.86	$506.60	$523.86	$531.60
Retiree + 1 (1 w/ Medicare)	$1,049.76	$1,089.78	$1,074.76	$1,114.78
Retiree + 1 (2 w/ Medicare)	$687.30	$713.14	$712.30	$738.14
Retiree + 2 or more (1 w/ Medicare)	$1,404.44	$1,451.32	$1,429.44	$1,476.32
Retiree + 2 or more (2 w/ Medicare)	$1,271.22	$1,326.02	$1,296.22	$1,351.02

Disease Prevention Discount Program

Tobacco use can really affect your game. Studies show tobacco users are more likely to have higher medical claims and are hospitalized longer. Smoking is a primary contributor to illnesses like heart, lung and pulmonary diseases that generally require long-term and costly medical intervention.

For those 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 discounted premium and you cover a tobacco user, you could lose medical coverage.

9 Which plan is right for me?

To help you decide which plan is right for you, the chart below gives you a comparison of plan details.

Are you over age 65 with Medicare? Save up to 95% on your health-care premiums. See the next page for more details.

Which plan is right for me?

Feature	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 rate.
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 U.S.
Service area	220 counties in Texas.	All 50 states, plus Puerto Rico.
Network services	Except for emergency care approved referrals, 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	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 for out-of-network.

A winning strategy - simple rules to keep health-care costs down

When you use your health care benefits responsibly, we all win. Doing so keeps you healthy and helps keep the amount the city spends on health care down. That's important, because the lower the city's health care costs, the lower your premiums. That's a grand-slam deal.

How can you help keep health-care costs down?

By following some simple rules:

- Exercise at least 30 minutes a day, most days of the week. This could be as simple as walking the dogs, cleaning the house or walking the stairs instead of taking an elevator at work.
- Give generic drugs a chance. They're the same in dosage and effectiveness as the brand-name drugs, but they're cheaper for you and the city.
- Research your illness to see if a trip to the doctor is necessary. Is it just a cold that will run its course? If so, those antibiotics that the doctor might prescribe won't do you any good.
- Watch your weight. Eat appropriate portions of the right kinds of foods.
- If you use tobacco, stop. See page 8 for details on how the city plans can help you do that.
- If you need immediate care but your PCP's office is closed, visit an urgent-care center instead. That can save you $110. (Emergency room visit: $150 - Urgent-care visit: $40)
- Get your free annual well-man or well-woman exam, which can catch illnesses and diseases early.

Medicare Advantage Plans

For Medicare-covered retirees and dependents only

Retirees and dependents covered by Medicare A & B can score some major league savings with an MA plan. Because the city offers three options, you can find which is perfect for you while saving baskets of money each month.

Aetna Private-Fee-for-Service offers copayment benefits for most services in all 50 states. Any doctor and hospital which accepts Medicare assignment and Aetna's terms and conditions can participate. As many as 96 percent of doctors in the U.S. who accept Medicare assignment may belong to this plan. 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 southwest Texas. 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 southeast/east Texas and three counties in the Valley. The network includes Kelsey-Seybold, Sadler Clinic and Renaissance doctors from which to select a PCP.

A scouting report on the benefits of the MA plan:

- TexanPlus and Texas HealthSpring have plan designs similar to HMO Blue Texas HMO.
- All three plans have prescription benefits similar to the HMO and PPO drug copayment structure.
- All three provide access to familiar retail pharmacies like CVS, Walgreens and others.
- All three give access to state-of-the-art medical facilities like St. Luke's and Methodist hospitals.
- Urgent care center locations so convenient, they're like a house call.
- The option for split-family elections – one member stays in HMO or PPO, one elects an MA plan.
- The opportunity to switch back to the HMO or PPO within 90 days of enrollment in an MA plan, or on Jan. 1, 2010, and again on May 1, 2010.

Put me in, Coach

If you or your dependent(s) are card-carrying members of Medicare and are enrolled in Part A, hospital insurance, and Part B, medical insurance, contact the Human Resources benefits division, 713-937-9400 or 888-205-9266, for more information regarding these money-saving Medicare Advantage plans.

Ask for the MA enrollment guide or get more information about the plans at www.houstontx.gov/hr/oe09.

Spotlight: A winning strategy

Here's how you score savings with an MA plan:

- If you are in the HMO and enroll in one of the three MA plans, you could save as much as 95 percent in premiums over what you're paying for HMO coverage.
- If you are in the PPO and enroll in the Aetna PFFS plan, you could save 88 percent over what you're paying for PPO coverage.
- Lower out-of-pocket costs on many services:
  - 25-70 percent on doctor visits
  - $200-$500 on hospital admissions
  - $100 on emergency-room visits
  - 5-10 percent on durable medical equipment, such as wheelchairs 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 and pharmacies

Important note for Medicare-covered PPO members seeing Kelsey-Seybold doctors

Due to the continuing gap between Medicare reimbursement and medical costs, effective Jan. 1, 2009, Kelsey-Seybold no longer provides services to PPO members covered by Medicare. If you are a Medicare-covered PPO member who seeks health care through Kelsey-Seybold, you will need to find a new doctor in the PPO directory, or you will have to change to the HMO or one of the MA plans. Kelsey-Seybold will continue to provide services to members in Texas HealthSpring, TexanPlus and HMO Blue Texas HMO.

11 Prescription plan highlights

You've managed this game so well, we can maintain the prescription benefit with only a couple of program notes. And for the most part, prescription benefits will stay the same. We've added two new step-therapy drug categories and the Triessent Specialty Drug Program.

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 copayments		
	Retail pharmacy (30-day supply)	**Mail-order pharmacy** (90-day supply)
Generic	$10	$20
Preferred brand	$30	$60
Non-preferred brand	$45	$90

Reviewing the rules of the prescription game

Mandatory generic

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 pay extra.

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 Zolpidem Tartrate	**$17.30**
You purchase brand-name Ambien	**$226.88**
Difference in price	**$209.58**
Your cost = price difference + $10 generic copayment	**$219.58**

Mail order

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

To switch your maintenance prescriptions to Prime Therapeutics and save 33 percent, get a mail-order form from your human resources liaison.

Step therapy

The step-therapy feature saves you money by requiring your doctor to consider alternative medications before prescribing higher-cost medications in seven categories:

- NEW Proton pump inhibitors for GERD, heartburn and stomach ulcers (Nexium, Prevacid, Protonix)*
- NEW Statins for high cholesterol (Lipitor, Vytorin, Zocor)*
- COX-2 inhibitors for inflammation/pain (Celebrex)
- Leukotrienes for asthma (Accolate, Singulair)
- Rheumatoid arthritis drugs (Enbrel, Humira, Kineret)
- ACE inhibitors for high blood pressure/congestive heart failure (Accupril, Mavik, Altace, Aceon)
- Angiotensin II receptor blockers for high blood pressure(Avapro, Atacand, Cozaar, Diovan)

*New. See page 4 for details.

New drugs may be added periodically.

What is step therapy?

To save you and the city money, the plans require your doctor to try a generic prescription before prescribing a higher-priced brand drug. If the alternative drug fails to alleviate your condition, your doctor can request authorization to step you up to the more-costly prescription.

Quantity versus time

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 nasal and asthma inhalers, migraine medications, 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.

Triessent Specialty Drug Program

High-cost specialty drugs, such as Enbrel or Tracleer, are now available exclusively through the Triessent Specialty Drug Program. Once you have signed up, Triessent will send a 30-day supply of the specialty medication to your home, your designated address or your doctor's office each month. The 30-day supply will cost you just $30 or $45. For more information, see page 4.

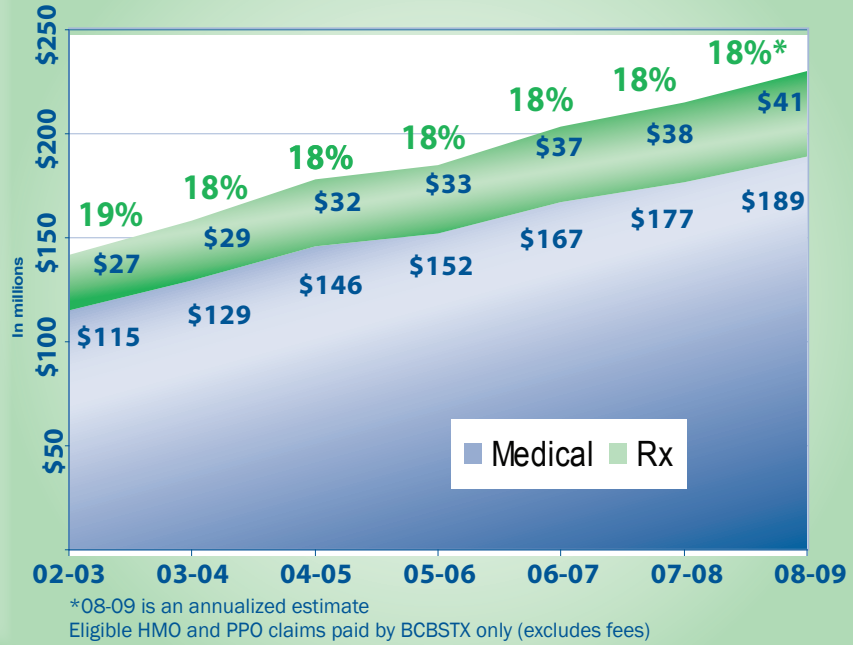
Top 10 prescriptions by amount spent

	Drug Treatment/Usual dosage	Copayment	Retail cost 30-day supply**
1	Nexium* GERD; 40 mg capsules; (Costco)	$30	$265
2	Lipitor* Cholesterol; 20 mg tablets; (CVS)	$45	$135
3	Enbrel* Rheumatoid Arthritis; (BCBSTX)	$30	$2,333
4	Actos Diabetes; 30 mg tablets; (CVS)	$30	$231
5	Prevacid* GERD; 15 mg capsules; (CVS)	$45	$182
6	Diovan* High Blood Pressure; 80 mg tablets; (CVS)	$30	$75
7	Valtrex Herpes Virus; 1000 mg caplets; (CVS)	$30	$382
8	Lantus Insulin; (BCBSTX)	$30	$160
9	Humira* Rheumatoid Arthritis; (BCBSTX)	$30	$2,312
10	Topamax Seizures/Convulsions; 50 mg tablets; (CVS)	$30	$290

NOTE: top 10 list is for all plans and all members. *Step-therapy drug. **Retail costs as of 10/31/2008 are listed on PharmacyChecker.com under Costco or CVS. Cost for drugs listed as BCBSTX are those paid by HMOBTX.

If you currently have a mail-order prescription for a brand-name proton pump inhibitor with Prime Therapeutics, you must ask your doctor for a new prescription. Otherwise, you will be charged for the full cost of the prescription plus the cost of the generic minus the generic copayment of $10. See "How mandatory generic works" on page 11 for an example.

Prescription as percent of total claims



*08-09 is an annualized estimate
Eligible HMO and PPO claims paid by BCBSTX only (excludes fees)

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.

Spotlight: A winning strategy

Want to save even more on your prescriptions? Wal-Mart, Sam's Club, Target, H-E-B, Walgreens, Randalls and Kroger offer 30-day supplies of hundreds of generic medications for just $4 or $5. That's half or less than your prescription drug copayment, saving you up to $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
- www.target.com/pharmacy
- www.kroger.com/generic
- www.randalls.com
- www.heb.com/pharmacy
- www.walgreens.com

13 Dental plan highlights

A bright white smile is important for your bubblegum card. The city offers you two affordable options to help keep your mouth healthy. After three years of no rate changes, both plan contributions will increase slightly.

Dental contributions

	Employee bi-weekly cost		Retiree monthly cost	
	from	to	from	to
DHMO				
Self only	$4.33	$4.50	$8.66	$9.00
Self + 1	$9.33	$9.70	$18.66	$19.40
Self + 2 or more	$13.20	$13.73	$26.40	$27.46
Dental Indemnity				
Self only	$12.50	$13.62	$25.00	$27.24
Self + 1	$28.91	$31.50	$57.82	$63.00
Self + 2 or more	$39.41	$42.95	$78.82	$85.90

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. The DHMO is provided by National Pacific Dental.

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
- A network that includes dentists and orthodontists

For a complete list of DHMO benefits and copayments, visit www.houstontx.gov/hr/oe09.

Insider's tip

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

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. The plan is provided by United Healthcare Inc.

How you use the plan:

- Make an appointment with the dentist of your choice.
- If the treatment will cost more than $200, get an estimate.
- Get a claim form from the Human Resources benefits division.
- Pay the dentist. Some dentists only require patients to pay their portion.
- File a claim for reimbursement within 90 days of the date of service. Some dentists will file your claim for you.
- **Mail the claim to:** United HealthCare Inc., 1445 North Loop West, Suite 500, Houston, Texas 77008
- Reimbursement is made by mail, usually within 10 days.
- To check on the status of a claim, call 866-605-2599.

For a complete list of services, 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 network of dental providers, you will receive a discount on your 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.

Example savings using a preferred dentist

Plan	Usual cost	50% coinsurance
Out-of-network	$875	$437.50
In-network	$701	$350.50
	Your savings	$87

To help you decide which plan is right for you, the chart below gives you a comparison of sample copayments for some common dental procedures. Both plans offer free preventive services and are tailored to help keep your mouth healthy.

Comparison of DHMO and dental indemnity plan features

Plan feature	DHMO Sample copayments	Dental Indemnity Sample copayments
Preventive services: 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 - $1,000 (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.
Service area	Counties include: 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 and Waller.	Anywhere in the United States.
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

Spotlight: Team information

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

15 Supplemental insurance plans

For active employees only

Like a good mouthpiece, these plans protect you against unexpected hits. And rates for these plans are staying the same as they were last year – the same rate they've been since 2001. You can enroll in these plans at any time.

Hospital-indemnity plan

The hospital-indemnity 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 expenses, even if they are not medical expenses. These payments are in addition to your city medical 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

The accident/disability plan provides a benefit if you or a covered dependent is injured or becomes disabled due to an accident covered by the plan. The plan will pay a scheduled benefit on or off the job for the following events:

- 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 administered by a doctor or hospital. These benefit payments are in addition to benefits paid by your city medical plan.

Personal cancer protection plan

The personal cancer protection plan provides supplemental insurance for you or a covered dependent diagnosed with cancer. Benefits are paid directly to you.

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

- House or apartment payment
- Utilities
- Car payments
- Copayments and deductibles
- Necessary household help
- Parking
- Child care
- Special equipment
- Gasoline
- Food and lodging

Rates and additional information

For more information on these supplemental insurance plans, including rates, contact your department human resources liaison or an AFLAC representative, 281-440-1133 or 281-440-3465.

Spotlight: Want to stay in the game?

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, 2010. All deductions are pretax, except for the disability plan.

Healthcare flexible spending account

For active employees only

A SMART game plan

The HFSA is a voluntary pretax benefit plan that allows you to set aside money from your paycheck to be reimbursed for out-of-pocket medical, prescription, dental and vision expenses incurred by you and your family. You can contribute up to $2,000 to your healthcare flexible spending account. When you buy an eligible item, you submit claims to FLEXONE, which will reimburse you via mail or direct deposit.

Get SMART! Ask your HR liaison for the SMART choice HFSA Enrollment Guide.

Why should I play?

Chances are, 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 those out-of-pocket costs. The money 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, hospitals 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.

Put me in, Coach

Enrollment is voluntary, and you must re-enroll if you want to continue. Ask your benefits liaison for the SMART Choice HFSA Enrollment Guide. It's filled with detailed information on how you can use this pretax benefit to lower your family's tax bill.

Tale of the tape — SMART Facts

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

Insider's tip

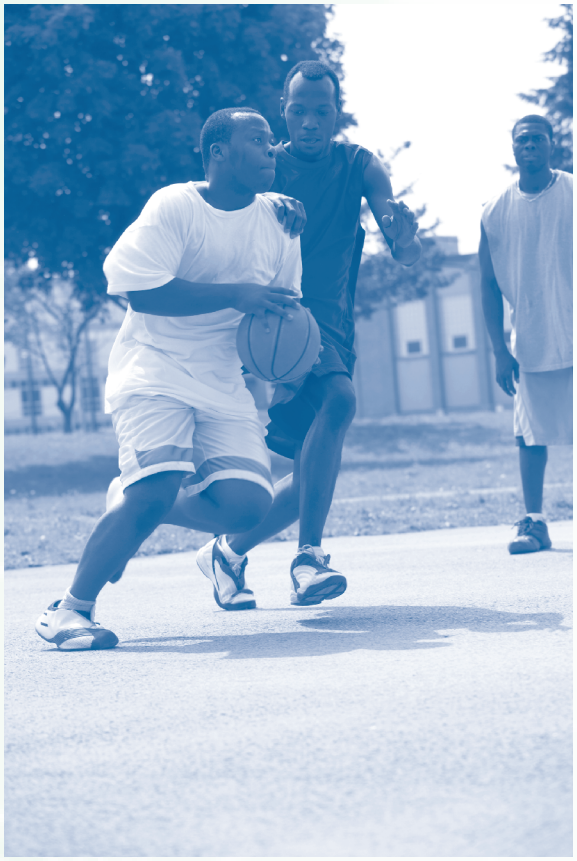
Don't forget, the Dependent Care Reimbursement program is another way you can save money. If you have qualifying expenses for dependent care, you can enroll in the plan in January. Watch for enrollment announcements in November.

For more information on how you can use this pretax benefit to lower your tax bill, visit www.houstontx.gov/hr/oe09 or ask your HR liaison for the SMART choice HFSA Enrollment Guide.

17 Section 125

For active employees only

Employees enrolled in medical, dental and supplemental insurance products can have deductions taken on a pretax basis, so your money goes further.



Pay lower taxes

Paying your contributions on a pretax basis will reflect a lower "taxable earnings" figure on your W2 – and that means you pay taxes on a lower amount. That usually means you see an increase in your take-home pay!

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

Here's an example of how you profit from paying for benefits with pretax dollars. This example is based on a married couple with three withholding allowances in 2009.

Example of pretax deduction savings

Pay/Deductions	Pretax	Post-tax
Gross biweekly pay	$1346.15	$1,346.15
Employee pretax HMO premium	-$122.39	$.00
Employee pretax DHMO premium	-$13.73	$.00
Taxable income	$1,210.03	$1,346.15
Federal withholding	-$36.14	-$53.81
Social Security withholding	-$92.57	-$102.98
Emp. post-tax HMO premium	$.00	-$122.39
Emp. post-tax DHMO premium	$.00	-$13.73
Net biweekly pay	$1,081.33	$1,053.24
Biweekly increase in take-home pay	**$22.56**	**$0**
Annual increase (24 checks) in take-home pay	**$661.33**	**$0**

Insider's tip

Section 125 is just one way of stretching your benefits dollars. Don't forget about the pretax Healthcare Flexible Spending Account. You must re-enroll if you want to continue in 2009. Learn more on page 16.

Spotlight: Stay in the game

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, 2010. Be sure to note the new premium rates and other changes on page 4.

Staying at the top of your game

In this game, it's important to stay in good shape. Use your health plans wisely – they'll help you 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 and well-woman screenings? Or that the DHMO and the Dental Indemnity plans offer preventive dental services for $0 copayment?

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

Blue Access: This provides online access at www.bcbstx.com to important information for health-plan members about their coverage and access to the Personal Health Manager and its wellness advice for you and your family.

Personal Health Manager: It's like having your own personal trainer and nutritionist to specifically design a healthier lifestyle for you. Online resources personalize a program for you. Log on through Blue Access and click on "Personal Health Manager" to start making some winning choices.

Special Beginnings: 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.

24/7 Nurseline: HMO members call 800-581-0353, and PPO members call 800-581-0368 for health issues that come up when you can't reach your doctor.

Wellness leave: The Compensable Sick Plan gives eight hours of paid time off per benefit year for preventative wellness activities. Activities include dental, vision, well-woman, well-man and physical exams, as well as other wellness-related doctor visits. Contact your benefits liaison for information.

50 free fitness facilities: You don't have to pay your way to fitness. The city offers free memberships to city fitness facilities all over Houston. You can ride stationary bikes, lift weights, swim, play basketball or play tennis. To find locations, visit www.houstonhumanresources.org and click on "Benefits Alerts."

Spotlight: Get a $50 gift card

It's easy to get a $50 gift card and an evaluation of your overall health: Just complete your Health Risk Assessment. Log on to www.bcbstx.com and click on "Personal Health Manager." Then click on "Health Risk Manager." 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 job satisfaction, risky lifestyle choices, stress, nutrition and sleep habits.

The first time you complete the assessment and authorize its release to BlueCross BlueShield, you'll be sent a $50 gift card to Academy in Texas or The Sports Authority for nonresidents. One card per employee/family. The card should arrive in about six weeks.

More immediately, you'll get important guideposts to making healthier lifestyle choices, improving your performance in the game. 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.

Rules of the game

Who is eligible?

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

- You're a full-time employee or part-time employee regularly scheduled to work at least 30 hours a week.
- You're a retiree who was covered by a city medical plan on the date of retirement from the city.
- You're a survivor of a covered city employee or retiree, up to age limits and application of other plan rules.
- You're a deferred-retired employee who will become eligible to receive a pension within five years after termination, and you continuously pay 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 defined as the following:

- Legal spouse
- Unmarried natural or adopted children to age 25, if they qualify as dependents for federal income-tax purposes
- Children to age 25, over whom you have legal guardianship or legal foster care if they qualify as dependents for federal income-tax purposes
- Grandchildren to 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 your dependents for federal income-tax purposes

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 consist with the status change.

Spotlight: Retirees and dependents

As of May 1, 2009, retirees may not add new dependents to their medical or dental plan. See page 3 for more details.

Qualified family-status changes

Qualified family-status changes include the following:

- 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.

Insider's tip

When your dependents become ineligible for coverage, they will be dropped from the medical and dental plans. You must submit a status-change form within 31 days to stop paying for their coverage.

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

If you don't drop them, but continue to pay the premiums, 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 HR benefits division at 611 Walker, 4th floor.

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 under age 25, if not added at time of birth or if you are requesting reinstatement of their coverage: birth certificate or legal document that establishes your paternity and a completed Certification of Financial Dependency form
- Children to age 25, over whom you have legal guardianship or legal foster care: copy of the legal documents granting custody, guardianship or foster care
- Grandchild(ren) to age 25, who are your covered dependent for federal income-tax purposes: Certification of Financial Dependency 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

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

Spotlight: Adding a new dependent

If you are enrolled in the HMO plan, and you do not add your new dependent within 31 days of the event that made the dependent eligible, 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 open enrollment.

21 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 them to the address below:

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

Spotlight: Employee Self Service

Track your personal stats online with the Employee Self Service system. You can access leave balances and usage, deductions and some paycheck stubs. You will also find forms to print and links to information for city employees. It's a secure site, and you'll only have access to your own records.

Give it a try: www.houstontx.gov/ess

If you're a new user, you will need to set up your password. Select "First time user" and follow the instructions. When you log in, the menu choices are in the blue bar on the left side of the screen.

If you have questions about your personal information, print the page and check with your payroll representative or HR liaison. For technical problems, contact the IT help desk.

If you have comments or suggestions, e-mail them to the "Contact us" address.

If you don't enroll now — active employees only

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 2010, unless you have a qualifying family-status change through loss of other group coverage.

Active Employees - life insurance only

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.

Employee Wellness Fair

Door Prizes

Goodies & Fun

George R. Brown Convention Center
Exhibit Hall B

Thursday, May 14
9 a.m. to 3 p.m.

Wellness Screenings

Fitness Demonstrations

Your completed forms must be given to your department human resources liaison by April 20, 2009. Any changes you make will be effective May 1,2009.

Retirees should use the postage-paid envelope in their packet to return their completed forms, or use the address on page 21.

If there exists a conflict between this Enrollment Guide and the official plan documents for each plan, the official plans documents will prevail. The city of Houston reserves the right to change, modify, increase or terminate any benefits.

Contacts

City of Houston Benefits Division
713-837-9400
888-205-9266
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
www.myuhcdental.com

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

Municipal Pension
713-759-9275
www.hmeps.org

Fire Pension
281-372-5100
www.hfrrf.org

Police Pension
713-869-8734
www.hpops.org

Great West (Deferred Compensation)
713-426-5588
www.houstondcp.gwrs.com

VALIC (HPD Deferred Compensation)
713-2276-7079
www.aigretirement.com/AIG-Retirement_82_8630.html

Retirees and dependents

As of May 1, 2009, retirees may not add dependents to their medical or dental plan. Dependents already covered may stay on your plan until they become ineligible. See page 3 for details..

Deferred-retired employees

If you are eligible to receive a pension within five years after you terminate employment, you are a deferred-retired employee and may keep your medical and dental coverage for you and your covered dependents. You may keep life insurance for yourself. You will pay the same premiums retirees pay. If you don't pay your premiums continuously, 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 one year 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 such as marriage, divorce, birth, adoption, or death, you may want to change your beneficiary.

If your spouse and you work for the city, you both have employee basic life insurance of one times your annual base salary. You cannot be your spouse's dependent. 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 an active employee, your covered surviving spouse and covered children may keep medical and/or dental coverage until your spouse remarries or becomes covered another group medical or dental plan. Single dependent children may be covered until age 25. Your spouse will pay employee-rate premiums.

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? How to keep your benefits

If you are an active employee and you do not receive a paycheck from the city and you want to retain your benefits, you must pay your premiums directly to the benefits division at 611 Walker, 4th floor. Premiums are not deducted from the check 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 ID card. Information will not be released over the phone.

Change of address

Active employees

When you change your mailing address, you also need to 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 city's HR 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 health-care premiums by cashier's check or money order, you may do so. Contact HR benefits at 713-837-9467 or 888-205-9266.