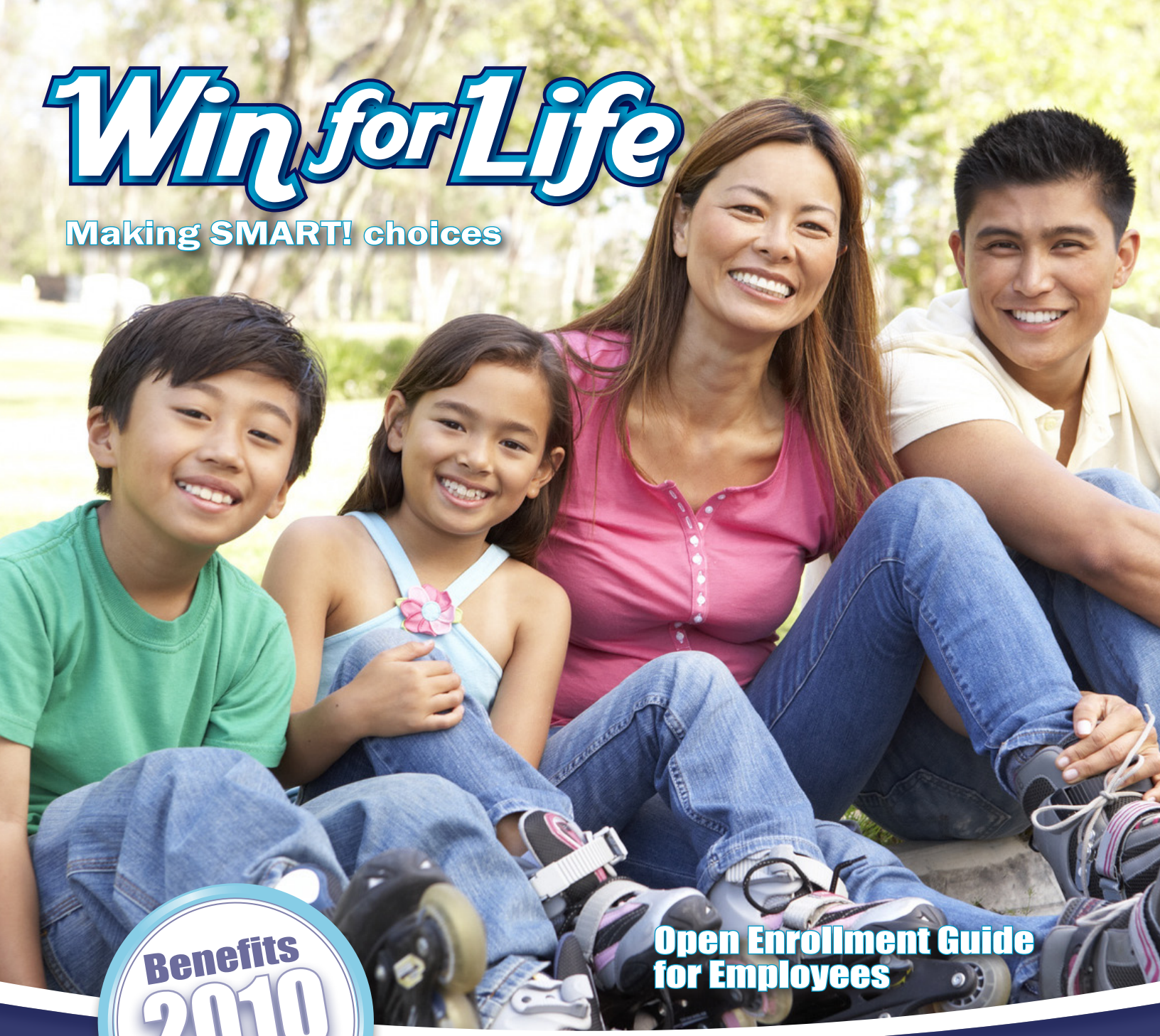
Win for Life

Making SMART! choices



Benefits 2010 Preview

Open Enrollment Guide for Employees

1 2010 Open Enrollment

A message from the coach

Dear Employees,

This city can't run without you, its dedicated and hard-working employees. It benefits the residents for you to be at your job and feeling healthy, so providing good health-care coverage for you and your loved ones is an important part of my new job. And I know that you deserve quality coverage as part of your employment with the city.

Health-care costs are expected to increase 9 percent nationwide in 2010. For the city, it's expected to increase from $289 million in FY10 to $311 million in FY11. Maintaining the high level of coverage and quality you have is important to me, but that means we'll all have to share some of the increased cost. I have served on the city's benefits committee for eight years. As a result, I can assure you that every option has been explored to keep the health plans affordable for you.

The city will maintain the 79 percent city, 21 percent employee ratio for active employees in the HMO plan, your most affordable option. But we're all going to have to pay a little more, and to help offset the increase, we've increased copayments for doctors' visits and non-generic prescription drugs by $5 starting May 1. Additionally, your contribution is increasing by an average of 8 percent for May 2010. You can find your new contributions listed on page 8.

I know it's tough to pay more. But it's the tough reality of health care today. I believe these new rates are very reasonable and certainly better than employees in other companies and industries are paying. Your dental coverage and DHMO rates are remaining the same. Rates will increase 9 percent for the indemnity dental plan.

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

You're all valuable partners helping us keep down health-care costs through wise use of your health-care dollars. If you continue to do that and we continue to work together, we should be able to retain quality, accessible and affordable benefits.

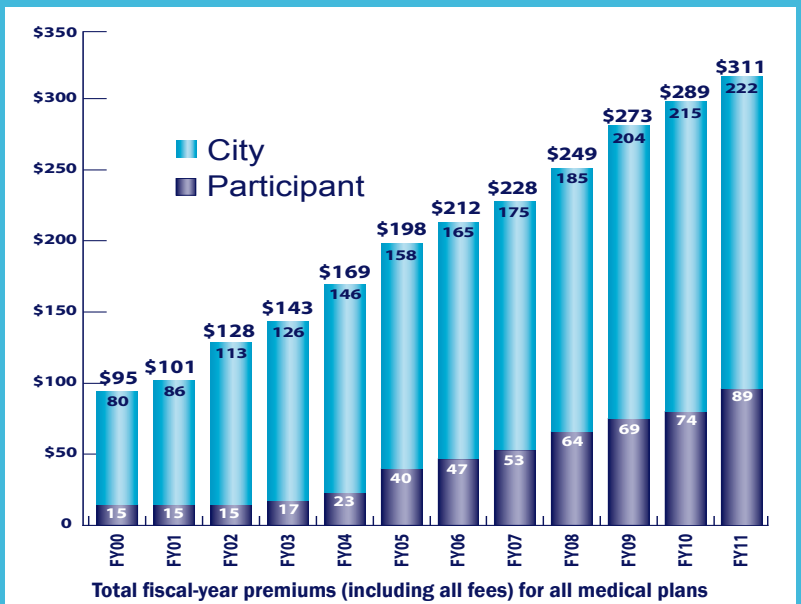
Respectfully,

Mayor

Insider's tip

If you are enrolled in the city's plans and don't want to make any changes – **don't do anything**. Your coverage will remain in effect through April 30, 2011. Be sure to note the new contributions and other changes on page 8.

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 open enrollment.

Health plans:

- HMO
- PPO

Dental plans

- Dental HMO
- Dental indemnity

Supplemental insurance plans

- Cancer
- Hospital
- Accident/disability

Flexible-spending account

- Health care

On the bench:

Other benefits offered year-round:

- 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, personal days for full-time employees and paid time-off for police officers

- Long-term disability – paid by the city, for 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 benefit
- Accrued leave donation program

Insider's tip

Don't forget -- HRSA participants must re-enroll every year if you want to coninue in the plan.

A few new plays for May 2010

- Doctor copayments are going up $5. For members of the HMO, a PCP visit will now cost you $25, and a specialist visit will cost you $50. For members of the PPO, a PCP visit will cost you $35, while a specialist visit will cost you $55. See page 3 for details.
- Copayments for brand-name prescription drugs are increasing $5 for a 30-day supply. Preferred brand-name drugs will be $35, and non-preferred brand-name prescriptions will be $50. Generic medications will remain $10 or less. See page 3 for details.
- With the opt-out opt-in feature, retiring employees can disenroll from their city medical and dental insurance and re-enroll during a future open enrollment or when they have a family status change. See page 4 for details.
- Your biweekly contributions to the medical plan will change. See pages 7-8 for the new rates.
- Time limitations on mental-health and substance-abuse treatment are being removed. See page 18 for details.
- By mid-May, HMO and PPO members will receive new ID cards to show the new copayments for prescription drugs, PCP, and specialists.

Contents

3 Health plan highlights

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, $25 in the HMO and $35 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, $50 in the HMO and $55 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

Because of the rising cost of health care, we've had to adjust the copayment structure for doctors' visits and prescription drugs. And for the first time, you can opt out of your city health plan at retirement and come back at a later date.

1. Copayments are changing

In an attempt to lessen the amount of your biweekly contribution increase, we're increasing your copayments slightly. As of May 1, HMO members will pay $25 when you visit your primary-care physician, and $50 when you visit a specialist. PPO members will pay $35 when visiting your primary-care physician, and $55 when you visit a specialist.

Copayments for preferred brand-name drugs and non-preferred brand-name drugs are increasing $5 for a 30-day supply and $10 for a 90-day mail-order supply. Generics will remain $10, or less for many drugs at many stores.

Changes in office visit copayments

	from	to
HMO PCP visit	$20	**$25**
HMO specialist visit	$45	**$50**
PPO PCP visit	$30	**$35**
PPO specialist visit	$50	**$55**

Changes in prescription copayments

	from	to
Preferred brand name 30-day supply	$30	**$35**
Non-preferred brand name 30-day supply	$45	**$50**
Preferred brand name 90-day supply mail-order	$60	**$70**
Non-preferred brand name 90-day supply mail-order	$90	**$100**

2. Retirees can opt out of their city insurance plan and return to the city insurance plan in the future.

Retirees will be able to disenroll from their city plan and re-enroll later. This Opt-out Opt-in feature could save you money during the opt-out period while providing you the security of knowing you can re-enroll in a city plan again in the future. See box on page 4 for detailed information.

New Opt-out Opt-in feature for retiring employees and retirees

As a retiree, you have come to expect city medical and dental benefits. In the past, if you waived these benefits, you couldn't come back to your city plan. Your only option was to keep the city's plan, even if you could get less-costly coverage somewhere else.

Now, you can opt out of your city benefits and re-enroll later. So when you and your spouse are no longer eligible for medical benefits from another source you can still get great city benefits coverage. Even if you have a city Medicare plan, you can opt out and return later.

For retirees, there are rules that Medicare plans must follow. So before you opt out, check with your plan administrator about how Medicare's rules will affect you. If you opt out of your city Medicare plan, you'll automatically be enrolled in Original Medicare, and you'll have to enroll in a prescription-drug plan if you want prescription-drug coverage. If you do not have a creditable Medicare Part D prescription-drug plan during your opt-out period, you may be limited to when you can enroll in a Part D plan and you may have to pay late-enrollment penalties.

Your opt-out applies to your dependents, including dependents covered under a Medicare plan. So if you drop your city coverage, your dependents' city coverage will be dropped as well.

You can opt back into a city plan during any open enrollment, after a family status change that causes you to lose coverage, or after a 90-day waiting period.

To opt out, you must submit a Retiree Medical/Dental Opt-Out form to HR benefits. Your opt-out election is effective the first of the month after HR benefits receives your form. For more information, call 713-837-9400.

To re-enroll, you'll need to submit a Retiree Medical/Dental Opt-In form to HR benefits and provide relationship documents for dependents you want to cover. If your opt-in election is caused by loss of coverage, you'll need to submit a Certificate of Coverage from the insurance company or the company that provided the medical plan. You must opt in within 31 days after the family status change, or you'll have to wait through the 90-day eligibility period.

Enrollment Materials Checklist

- ☐ Open enrollment guide
- ☐ Comparison chart
- ☐ Employee or retiree medical/dental forms
- ☐ SMART! guide

Who's in the game?

Who	HMO	PPO	Total
Employees	21,366	496	21,862
Retirees	6,817	368	7,185
Dependents	36,654	385	37,039
MA enrollees			2,834
Total	64,837	1,249	68,920

Data Date: 12/31/2009

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		$25	$35	40%
Specialist office visit copayment		$50	$55	40%
Routine physical copayment		$0	$0	40%
Well woman/man exam		$0	$0	40%
In-patient admission copayment/coinsurance		$500	$500 + 20%	$1000 + 40%
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	$35	$35	$35
	Non-preferred brand	$50	$50	$50
Mail-order pharmacy (90-day supply)	Generic	$20	$20	$20
	Preferred brand	$70	$70	$70
	Non-preferred brand	$100	$100	$100

*Generics are mandatory if available.

Doctors in the HMO and PPO		
Physician group	**HMO**	**PPO**
Baylor		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
Texas Children's Physician Group	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.

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.

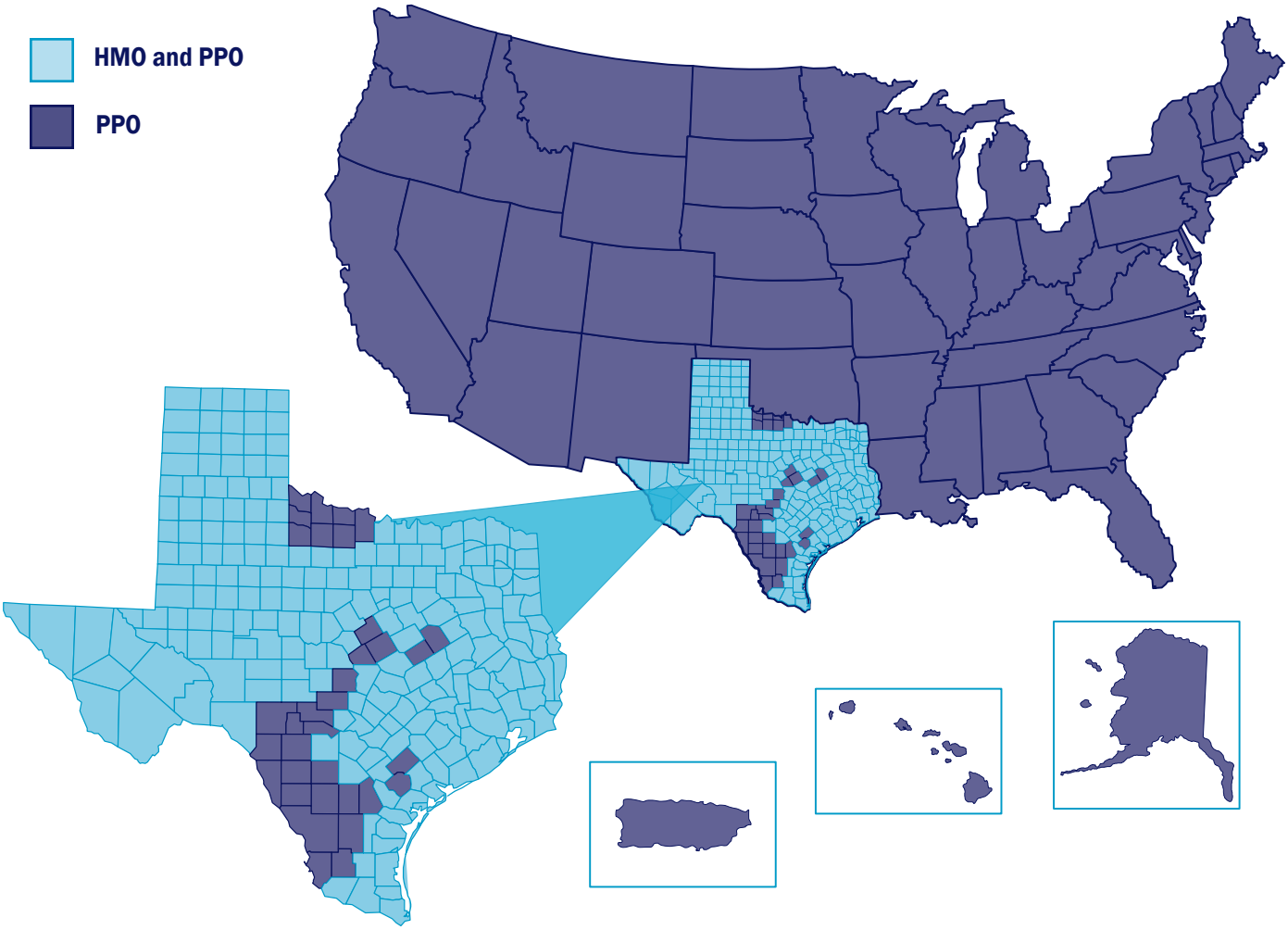
PPO

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/oe10.



1 Contributions

The team budget

Health care, like sports, is a big-bucks world. And the 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 have to take on some of the increased costs.

In FY11, the city expects to spend $311 million for health care, up from $289 million last year. By slightly increasing copayments for doctor's visits and some prescription medications and by creating a state-approved trust to save taxes on premiums paid by the city for health care, we've been able to contain the increase in premiums. Overall, premiums went up 5.07 percent this year in the HMO, compared to the 8 percent BCBSTX proposed. PPO contributions are going up 12 percent.

The city contributes 79 percent for active employees in the HMO and 73 percent for active and retired employees combined.

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.

Here's what that means to you:

- HMO rates will increase 8 percent on average.
- PPO employee contributions will increase about 22 percent on average.

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.

Monthly rate comparison

Company (Predominant Plan)	Tier	Employee's contribution	Employer's contribution
City of Houston (HMO)	EE only	$38	$329
	EE + family	$265	$898
Private local institution (HMO)	EE only	$64	$337
	EE + family	$411	$831
HISD (HMO)	EE only	$94	$139
	EE + family	$444	$152
Harris County (PPO)	EE only	$0	$462
	EE + family	$367	$829
Private local company (PPO)	EE only	$110	$329
	EE + family	$362	$918

Source: City of Houston annual health benefits survey, January 2010. City of Houston data effective 5/1/10. Other participants' data valid YTD 2009. Amounts rounded to whole dollars.

New rates are effective May 1, 2010

Active employees' bi-weekly contributions (24 times per year)				
	Wellness discount		Tobacco user	
HMO	**From**	**To**	**From**	**To**
Employee Only	$18.13	$19.05	$30.63	$31.55
Employee + 1	$99.68	$108.08	$112.18	$120.58
Employee + 2 or more	$122.39	$132.71	$134.89	$145.21
PPO and Out-of-Area	**From**	**To**	**From**	**To**
Employee Only	$124.80	$153.50	$137.30	$166.00
Employee + 1	$356.90	$432.30	$369.40	$444.80
Employee + 2 or more	$460.61	$559.02	$473.11	$571.52

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 brand-name drugs, but they're cheaper for you and the city.
- If you use tobacco, stop.
- 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 the doctor might prescribe won't do you any good.
- Call nurse line at 800-581-0353
- Know your numbers. (Cholesterol, blood pressure, blood sugar, BMI and more.)
- Watch your weight. Eat appropriate portions of the right kinds of foods.
- If you need immediate care but your PCP's office is closed, visit an urgent-care center instead. That can save you $110. (HMO 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.

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.

Which plan is right for me?		
Feature	**HMO**	**PPO**
Concept	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 and referrals).	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	1,397 PCPs, 4,517 specialists and 2,525 hospital-based physicians in 19 counties around the Houston-Galveston area. Network doctors throughout Texas.	2,615 PCPs, 6,171 specialists and 3,052 hospital based physicians in 19 counties around the Houston-Galveston area. More than 720,000 doctors across the U.S.
Service area	220 counties in Texas.	All 50 states, plus Puerto Rico.
Network services	Except for emergency care and 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.	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 $25.	Most common copayment is $35 in-network.
Specialist visit	Most common copayment is $50.	Most common copayment is $55 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.

Get a $50 gift card

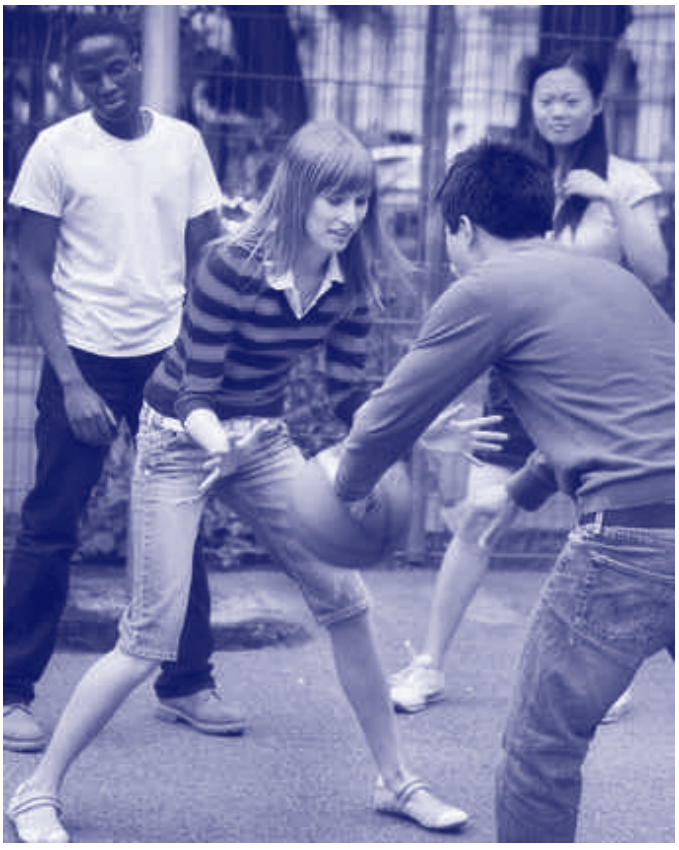
It's easy to get a $50 gift card and an evaluation of your overall health: Just complete your Health Risk Assessment. Log on to www.bcbstx.com and click on "Personal Health Manager." Then click on "Health Risk Manager." The assessment is a short series of easy-to-answer questions. You'll then receive 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.

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.



Spotlight: Nearing retirement?

If you are an employee over age 65 and considering retirement, you might want to think about a Medicare plan to replace your BCBSTX plan after you retire. You can save a lot of money – up to 98 percent of the cost of HMO coverage for retiree only, and 85 percent or more of the cost of PPO coverage. For more information regarding these money-saving plans, contact the Human Resources benefits division, 713-837-9400 or 888-205-9266.

11 Prescription plan highlights

You've managed this game so well, we can continue the prescription benefit with only a couple of program notes. And for the most part, prescription benefits will stay the same. This is a three-tier prescription plan, with different copayments in each tier. The brand name copayments will increase by $5, making preferred brand $35 and non-preferred brand $50. Drugs are assigned to the tiers based on the BCBSTX formulary, which can change annually, usually in May. To find out which drugs are in each of the three tiers, go to www.bcbstx.com.

Prescription copayments		
	Retail pharmacy (30-day supply)	**Mail-order pharmacy** (90-day supply)
Generic	$10	$20
Preferred brand	$35	$70
Non-preferred brand	$50	$100

Reviewing the rules of the Rx 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 metoprolol tartrate	**$30.66**
You purchase brand-name Lopressor HCT	**$170.06**
Difference in price	**$139.40**
Your cost = price difference + $10 generic copayment	**$149.40**

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 www.bcbstx.com or request HR benefits send one to you.

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:

- **Proton pump inhibitors** for GERD, heartburn and stomach ulcers (Nexium, Prevacid, Protonix)*
- **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 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. The list of drugs that are subject to quantity limits can change. To find an updated list, visit www.bcbstx.com or call 800-521-2227.

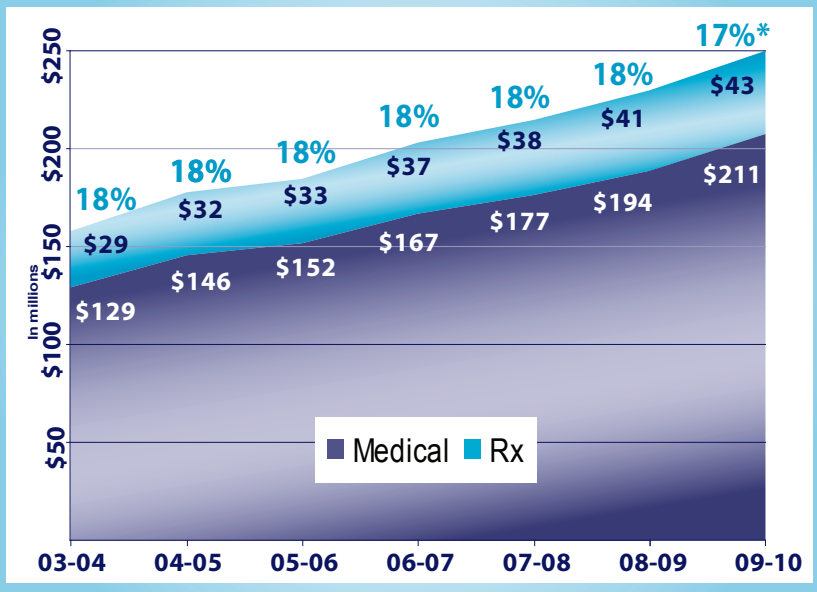
Triessent Specialty Drug Program

High-cost specialty drugs, such as Enbrel or Tracleer and those administered through home infusion, are 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 $35 or $50.

Top 10 prescriptions by total money spent			
	Drug/Treatment	Your copayment	Plan pays
1	Lipitor* / cholesterol	$50	$155
2	Plavix / stroke and heart attack	$35	$200
3	Actos / diabetes	$35	$255
4	Enbrel** / rheumatoid Arthritis	$35	$2,062
5	Nexium* / GERD	$35	$224
6	Crestor* / cholesterol	$35	$149
7	Valtrex / herpes Virus	$35	$260
8	Humira** / rheumatoid Arthritis	$35	$2,033
9	Advair diskus / asthma	$35	$234
10	Tricor* / cholesterol	$35	$153

NOTE: top 10 list is for HMO only - 12/31/2009.
*Step-therapy drug.
**Specialty drugs must be ordered through Triessent

Prescriptions as percent of total claims



*09-10 is an annualized estimate
Eligible HMO and PPO claims paid by BCBSTX only (excludes fees)

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. Your contributions remain the same as last year for the DHMO, but increase 9 percent in the indemnity plan.

Dental contributions		
	Employee bi-weekly cost	
DHMO (No Change)		
Self only	$4.50	
Self + 1	$9.70	
Self + 2 or more	$13.73	
Dental Indemnity		
	from	to
Self only	$13.62	$14.85
Self + 1	$31.50	$34.34
Self + 2 or more	$42.95	$46.82

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. 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/oe10.

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 UnitedHealthCare 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**

Your dental plan benefits have not changed in either the DHMO or the indemnity plan. 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, Bexar, 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

Like a good mouthpiece, these plans protect you against unexpected hits. Contributions for these plans are staying the same as last year – the same as they've been since 2001. You can enroll in these plans during open enrollment.

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, 2011. Deductions are pretax, except for the disability plan.

Healthcare flexible spending account 16

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 incur an eligible expense, 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 each year 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

Claim form: www.aflac.com/us/en/docs/benefits/flexclaim.pdf

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/oe10 or ask your HR liaison for the SMART! choice HFSA Enrollment Guide.

17 Section 125

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 benefit from paying for benefits with pretax dollars. This example is based on a married couple with three withholding allowances in 2010.

Example of pretax deduction savings

Pay/Deductions	Pretax	Post-tax
Gross bi-weekly pay	$1,500.00	$1,500.00
Employee pretax HMO premium	-$132.71	$.00
Employee pretax DHMO premium	-$13.73	$.00
Taxable income	$1,353.56	$1,500.00
Federal withholding	-$40.36	-$61.83
Social Security withholding	-$83.92	-$93.00
Medicare withholding	-$19.63	-$21.75
Emp. post-tax HMO premium	N/A	-$132.71
Emp. post-tax DHMO premium	N/A	-$13.73
Net biweekly pay	$1,209.65	$1,176.98
Biweekly increase in take-home pay	**$32.67**	**$0**
Annual increase in take-home pay	**$784.08**	**$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 2010. 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, 2011. Be sure to note the new contributions on page 8.

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. Classified police officers have paid time off and do not have CSL wellness hours. 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.houstontx.gov/parks/fitnesscenters.html.

BlueExtras: A discount program that provides you and your dependents access to discounted health-care products and services, such as alternative medicine and weight management programs. There is no additional fee, no required referrals or pre-authorizations, and no limits to how many times you and your covered dependents can use the discounts. Visit www.bcbstx.com to learn more.

Fitness program membership: This program offers access to a nationwide network of independent fitness centers for a low one-time $29 enrollment fee and $29 monthly fee, plus taxes, available exclusively to BlueCross BlueShield of Texas members and their covered dependents, 18 years or older. Visit www.bcbstx.com to learn more.

Mental Health Parity

The Federal Mental Health Parity and Equity Act requires HMO plans to remove time limitations from treatment of mental health and substance abuse. Starting May 1, out-patient and in-patient services will be treated like any other medical condition.

HMO

- The 30-day in-patient limitation for mental illness will be removed.
- The three series of treatments of chemical dependency will be removed.
- The 20 office visits per calendar year limitation will be removed.

Copayments, including those for PCPs and specialists, remain the same: out-patient copayment is $25 per visit; in-patient coinsurance is 20 percent of the cost.

PPO

- The 30 outpatient visits per calendar year will be removed.
- The three series of treatments of chemical dependency will be removed.
- The 30-day in-patient limitation for mental illness will be removed.

Copayments, coinsurance and the plan's deductable will remain the same: out-patient is the office copayment plus 20 percent; in-patient is $500 plus 20 percent.

In June 2010, you should expect to receive a new benefits summary that will provide details of these improved benefits.

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 and listed as PT30.
- You're a survivor of a city employee or retiree who was covered at the time of their death, 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.

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.

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 and step-children to age 25 if they live with you and 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
- Dependents for whom a court order has been received requiring the employee or retiree to provide health care coverage, provided HR benefits receives the court order within 31 days after issuance. After a divorce, an ex-spouse is not eligible. A divorce decree may not be amended to require an employee or retiree to cover an ex-spouse under a city medical plan.

Changes to your benefits are limited to open-enrollment periods, unless you have a qualified change in family status. In that case, the change in benefits must be consistent with the status change.

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 before age 25
- 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 benefits-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 from the date you receive your notice, and you may be responsible for any claims incorrectly paid on their behalf.

You can get a benefits-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 certificate
- Common-law spouse: certified 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
- Stepchildren to age 25: 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
- Court ordered dependent coverage: copy of court order mandating coverage, including date of the court order.

There is no waiting period for dependents added 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.

You can also submit your forms to HR benefits, 611 Walker, 4th floor.

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

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 2011, unless you have a qualifying family-status change through loss of other group coverage.

Life insurance

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.

Your completed forms must be given to your department human resources liaison by April 20, 2010. Any changes you make will be effective May 1, 2010.

If there exists a conflict between this Enrollment Guide and the official plan documents for each plan, the official plan 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

Rules to 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 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. You may also opt out of retiree coveage and re-enroll in the future.

Long-term disability

If you were hired after September 1985 and are a 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, or within 60 days after termination for a disability that occured before termination of employment. 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. Your spouse's maximum coverage is $50,000. A child's maximum coverage is $10,000.

Medical/dental coverage

If you die while an employee, your covered surviving spouse and covered children may keep medical and/or dental coverage until your spouse remarries or becomes covered under another group medical or dental plan. Single dependent children may be covered until age 25. Your spouse will pay employee-rate premiums.

If a work-related accident, injury or exposure causes your death, your covered surviving spouse may keep medical/dental coverage until he or she becomes eligible for Medicare or become covered under another group plan.

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 plus a 2 percent administrative fee. 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 but 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

When you change your mailing address, you also need to update your address with your HR liaison or payroll representative, and when your address is updated in the city's system, the new address transfers to the benefits carriers. To receive important information about your medical and dental plans, your address must be current at all times.

Opt-out Opt-in feature

Retirees can opt out of their city health benefits plans and re-enroll in the future. To opt out, you must submit a Retiree Medical/Dental Opt-out form to HR benefits. Your opt-out election will be effective the first of the following month. Remember, your opt-out applies to your dependents. You can opt back into a city plan during any open enrollment, after a family-status change that causes you to lose coverage elsewhere, or after a 90-day waiting period. To re-enroll, you will need to submit a Retiree Medical/Dental Opt-in form to HR benefits and provide relationship documents for dependents.