City of Houston

HR

# Your Health & Welfare Benefits After Retirement

# OVERVIEW

- How do I apply for retirement?
- What benefit options do I have at retirement?
- How do I continue my current benefits after retirement?
- General Guidelines for Retirement
- Opt-Out\Opt-in Guidelines
- Medicare Eligibility and City-Sponsored Medicare Plans
- Contact Information

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# How do I apply for retirement?

- **Step 1:** Contact your Pension System to determine your eligibility status for retirement or deferred retirement

  - **Houston Municipal Employee Pension System**
    1200 Louisiana, Suite 900, Houston TX 77002
    713.595.0100 / www.hmeps.org

  - **Houston Firefighters' Relief and Retirement Fund**
    4225 Interwood North Parkway, Houston TX 77023
    281.372.5100 / www.hfrrf.org

  - **Houston Police Officers' Pension System**
    602 Sawyer, Suite 300, Houston TX 77007
    713.869.8734 / www.hpops.org

- **Step 2:** Contact the HR Client Relations Manager that services your department to complete any other information that is needed to begin the retirement process.

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# What benefit options do I have at retirement?

As a new retiree you have the option to continue with your current Medical, Dental, Vision, and Life Insurance or opt out of coverage completely.

| OPTION 1 | OPTION 2 |
|---|---|
| Keep existing coverage and pay retiree rates | Opt-Out of coverage ***(eligible to return at later date)*** |
| • Medical<br>• Dental<br>• Vision<br>• Life Insurance<br>• Supplemental Plans | • Medical<br>• Dental<br>• Vision<br>• Life Insurance |

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# How do I continue or opt out of my current benefits?

**Opt-In/Opt-out Medical/Dental/Vision form**

RETIREE/SURVIVOR Medical/Dental/Vision Form

BENEFITS DIVISION, P.O. BOX 248, Houston, TX 77001-0248

PRINT OR TYPE WITH BLUE OR BLACK INK ONLY

Employee I.D. Number | Pension System | Social Security No. | Sex

☐ Municipal ☐ Fire ☐ Police ☐ Male ☐ Female

Last Name | First Name | M.I. | (Area Code) Phone

Address (Check box if address change) ☐ | Apt No. | City | State | Zip Code

A. Group Benefits Choice

Note: The City's six (6) Medicare plans are available to retirees/dependents who are Medicare eligible and covered under Medicare Parts A & B. The CIGNA plans are not available to Medicare-eligible retirees and their Medicare-eligible dependents.

Medical Plan (select one):
- ☐ Cigna Limited Network Plan
- Cigna KelseyCare
- Renaissance
- Memorial Hermann Health Network
- ☐ Cigna Open Access
- ☐ Consumer Driven Health Plan
- ☐ Retirees of Texas Option Plus

Dental Plan (select one):
- ☐ DHMO Plan
- ☐ DPPO Plan

Vision Coverage Type:
- ☐ Retiree/Survivor Only
- ☐ Retiree + Spouse
- ☐ Retiree/Survivor + Child(ren)
- ☐ Retiree + Spouse and Child(ren)

Dental Coverage Type:
- ☐ Retiree/Survivor Only
- ☐ Retiree/Survivor + 1 Dependent
- ☐ Retiree/Survivor + 2 or More Dependents

Medical Coverage Type:
- ☐ Retiree/Survivor Only
- ☐ Retiree + Spouse
- ☐ Retiree/Survivor + Child(ren)
- ☐ Retiree + Spouse and Child(ren)

OPT OUT:
I understand that I may re-enroll in the future.
- ☐ Medical
- ☐ Vision
- ☐ Dental

B. Complete this Section

| Person (Circle One) | Male | Female | Medical (Add/Drop) | Vision (Add/Drop) | Dental (Add/Drop) | Last Name, First, M.I. | Social Security Number | Date of Birth |
|---|---|---|---|---|---|---|---|---|
| Retiree/Survivor | | | | | | | | |
| Husband/Wife | | | | | | | | |
| Child/Stepchild/Grandchild | | | | | | | | |
| Child/Stepchild/Grandchild | | | | | | | | |
| Child/Stepchild/Grandchild | | | | | | | | |

NOTE:
**Eligible Dependent**-An eligible dependent means your legal spouse and any child (natural, adopted, foster, grandchild, stepchild, and a child for whom you are legal guardian and/or have legal support obligation) who is your dependent for federal income tax purposes , resides with you, and is under age 25.

**Overage Dependent**-A dependent child who is 25 or older, primarily supported by you, and incapable of self-sustaining employment by reason of mental incapacity, physical disability or handicap which arose while the child was covered as a dependent under these Plans, or while covered as a dependent under prior City Plans without a break in coverage. Upon applying and receiving third party medical administrator's approval, proof of the child's condition and dependence must be submitted within 31 days or the child cease to qualify for benefits.

**Relationship documents: certified marriage certificate, Registration and Declaration of an Informal Marriage certificate (common law), legal and court order documents, and official birth certificates or birth facts.**

I authorize any medical, vision of dental provider of facility to disclose to the plan administrator medical, vision of dental information relating to individuals specified on this application.

C. Tobacco User Status

- ☐ Check this box if you and/or your dependents **use tobacco** products. You are not eligible for the monthly voluntary disease prevention discount of $25.00. If all covered persons stop using tobacco products for 60 consecutive days, you may apply for the voluntary disease prevention discount withing the following 31 days. When you apply for the discount, you must not have any covered tobacco product users.
- ☐ Check this box if you and/or your dependents **do not use tobacco** products. You qualify for the voluntary disease prevention discount of $25.00 monthly.

D. Authorization of Deduction from Pension Check

I am a retiree or survivor of the City of Houston, eligible to participate in the medical, vision, and dental programs. I apply to make the above coverage election and understand that information I have provided is a part of my application. All statements made by me may be relied upon by the City, if any information that I have provided is found to be materially incorrect, my coverage may be denied. Once the enrollment deadline has past, my plan elections are binding until the next open enrollment period, however, I may opt out of the plan at any time. Completed enrollment forms and documentation of qualifying life events will be required within 31 days of the event. Supporting documents for newly-added dependents are required within the 31-day time period of the life changing event. If documents are not received within the 31 days of the life changing event coverage will not be active for any dependents. Therefore, dependents coverage will be delayed until next open enrollment or a qualifying life event.

I agree that if I acquire other coverage outside of the City of Houston medical, dental and vision plans or if I have listed ineligible dependents, I may incur a monetary penalty and/or my medical, vision, and dental coverage will be canceled. I authorize the pension system to deduct from my pension check my portion of the contribution as it becomes due.

I understand that I must notify the City of Houston when I acquire other coverage outside of the City of Houston's medical, dental and vision plans and when I have an ineligible dependent. Medical, dental, and vision plan contributions are paid one month in advance. If you opt out or make a plan or tier change at the end of the month, you may be eligible for a refund for contributions already paid.

Date: | Contact Phone No. | Signature:

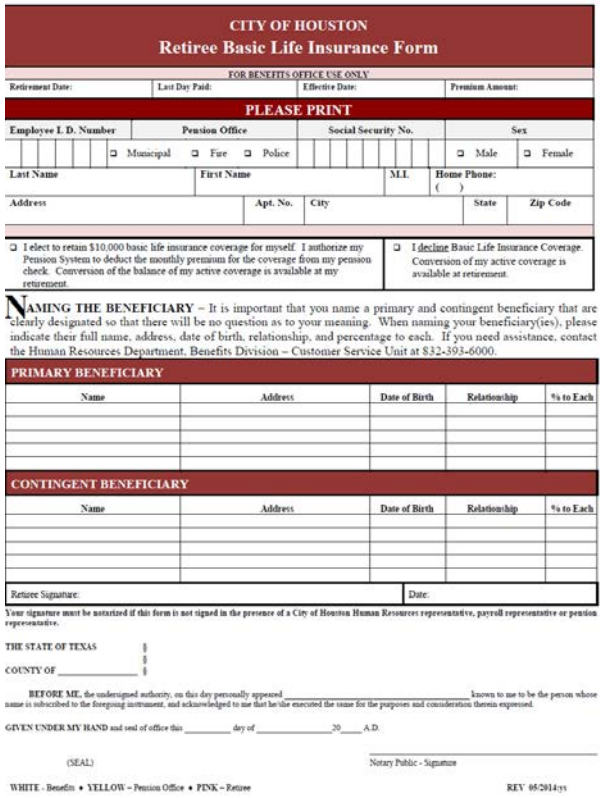
FOR BENEFITS DIVISION USE ONLY

Department: | Retirement Date: | Effective Date:

WHITE – Benefits • GOLD – Retiree

2017_RetireeSurvivor_MVD_Form.ai - rev. 02/17

**Retiree Basic Life Insurance form**



CITY OF HOUSTON

Retiree Basic Life Insurance Form

FOR BENEFITS OFFICE USE ONLY

Retirement Date: | Last Day Paid: | Effective Date: | Premium Amount:

PLEASE PRINT

Employee I. D. Number | Pension Office | Social Security No. | Sex

☐ Municipal ☐ Fire ☐ Police ☐ Male ☐ Female

Last Name | First Name | M.I. | Home Phone: ( )

Address | Apt. No. | City | State | Zip Code

☐ I elect to retain $10,000 basic life insurance coverage for myself. I authorize my Pension System to deduct the monthly premium for the coverage from my pension check. Conversion of the balance of my active coverage is available at my retirement.

☐ I decline Basic Life Insurance Coverage. Conversion of my active coverage is available at retirement.

**NAMING THE BENEFICIARY** – It is important that you name a primary and contingent beneficiary that are clearly designated so that there will be no question as to your meaning. When naming your beneficiary(ies), please indicate their full name, address, date of birth, relationship, and percentage to each. If you need assistance, contact the Human Resources Department, Benefits Division – Customer Service Unit at 832-393-6000.

PRIMARY BENEFICIARY

| Name | Address | Date of Birth | Relationship | % to Each |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

CONTINGENT BENEFICIARY

| Name | Address | Date of Birth | Relationship | % to Each |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Retiree Signature: | Date:

Your signature must be notarized if this form is not signed in the presence of a City of Houston Human Resources representative, payroll representative or pension representative.

THE STATE OF TEXAS §

COUNTY OF _____ §

BEFORE ME, the undersigned authority, on this day personally appeared _____ known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he/she executed the same for the purposes and consideration therein expressed.

GIVEN UNDER MY HAND and seal of office this _____ day of _____ 20____ A.D.

(SEAL)

Notary Public - Signature

WHITE - Benefits • YELLOW – Pension Office • PINK – Retiree

REV 05/2014/ys

City of Houston HUMAN RESOURCES

**PDF fillable forms are available at www.cityofhoustonbenefits.org**

# General Guidelines for Retirement

- You must be enrolled in a Medical, Dental, or Vision plan at the time of your retirement to continue or opt-out of your plan. If you waived any coverage as an active employee you can't obtain the coverage as a retiree.
- Upon retirement you can choose to remain in your current benefit plan. You can only change plans if you are enrolled in the Cigna Limited Plan and/or the DHMO dental plan, and you reside or plan to move outside of the coverage area.
- As a retiree you can add dependents due to qualifying events such as (marriage, birth, loss of coverage) and you can drop dependents at anytime.

# Opt-In/Opt-Out Guidelines

- You can choose to opt-out of any plan you currently have at the time of your retirement or after your retirement at anytime. **You must complete form to opt-out.**
- You can opt-in during the Open Enrollment period that occurs in March and be effective May 1 of that same plan year.
- You can also opt-in if you obtained other insurance coverage while you were opted-out of the City of Houston's plan and you are losing that coverage.

# Are you Medicare eligible?

- You must be enrolled in Medicare Parts A & B through the Social Security Administration to enroll in a City of Houston-sponsored Medicare plan.
- Failure to enroll in a City of Houston-sponsored Medicare plan will result in termination of coverage under the Cigna plan at the end of the month you become Medicare eligible
- If you are already Medicare eligible, **contact the Benefits Division at least two months before you retire**:
    - Call: 832-393-6000
    - Email: retireebenefits@houstontx.gov
    - Visit: 611 Walker, 4th Floor, Houston, TX 77002

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# City of Houston Sponsored Medicare Plans *(rates effective 1/1/2020)*

| PLAN | Monthly contribution per person |
|---|---|
| Aetna Steerage PPO | $64 |
| KelseyCare Advantage HMO | $49 |
| Medicare Supplement Plan F/G | $116 |
| Cigna HealthSpring HMO | $29 |
| WellCare TexanPlus HMO | $23 |

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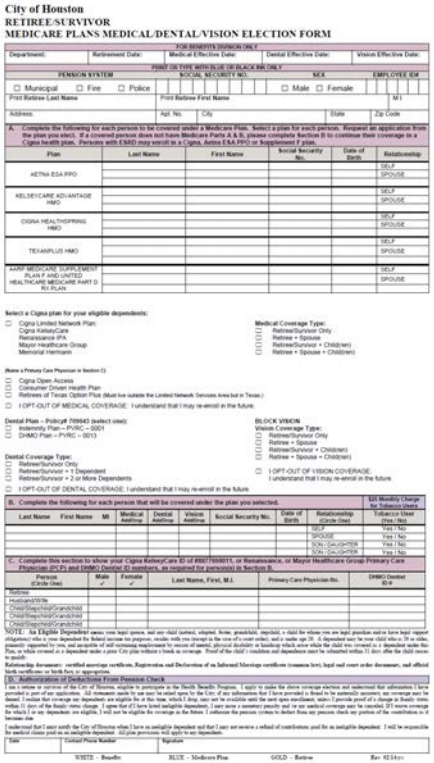
# Medicare Retiree Paperwork

**Retiree Medicare**
**Medical/Dental/Vision form**



**City of Houston**
**RETIREE/SURVIVOR**
**MEDICARE PLANS MEDICAL/DENTAL/VISION ELECTION FORM**

FOR BENEFITS DIVISION ONLY

| Department: | Retirement Date: | Medical Effective Date: | Dental Effective Date: | Vision Effective Date: |
|---|---|---|---|---|

PRINT OR TYPE WITH BLUE OR BLACK INK ONLY

| PENSION SYSTEM | SOCIAL SECURITY NO. | SEX | EMPLOYEE ID# |
|---|---|---|---|
| ☐ Municipal ☐ Fire ☐ Police | | ☐ Male ☐ Female | |

| Print Retiree Last Name | Print Retiree First Name | MI |
|---|---|---|
| | | |

| Address: | Apt. No. | City | State | Zip Code |
|---|---|---|---|---|
| | | | | |

A. Complete the following for each person to be covered under a Medicare Plan. Select a plan for each person. Request an application from the plan you elect. If a covered person does not have Medicare Parts A & B, please complete Section B to continue their coverage in a Cigna health plan. Persons with ESRD may enroll in a Cigna, Aetna ESA PPO or Supplement F plan.

| Plan | Last Name | First Name | Social Security No. | Date of Birth | Relationship |
|---|---|---|---|---|---|
| AETNA ESA PPO | | | | | SELF |
| | | | | | SPOUSE |
| KELSEYCARE ADVANTAGE HMO | | | | | SELF |
| | | | | | SPOUSE |
| CIGNA HEALTHSPRING HMO | | | | | SELF |
| | | | | | SPOUSE |
| TEXANPLUS HMO | | | | | SELF |
| | | | | | SPOUSE |
| AARP MEDICARE SUPPLEMENT PLAN F AND UNITED HEALTHCARE MEDICARE PART D RX PLAN | | | | | SELF |
| | | | | | SPOUSE |

Select a Cigna plan for your eligible dependents:

☐ Cigna Limited Network Plan:
Cigna KelseyCare
Renaissance IPA
Mayor Healthcare Group
Memorial Hermann

Medical Coverage Type:
☐ Retiree/Survivor Only
☐ Retiree + Spouse
☐ Retiree/Survivor + Child(ren)
☐ Retiree + Spouse + Child(ren)

(Name a Primary Care Physician in Section C)

☐ Cigna Open Access
☐ Consumer Driven Health Plan
☐ Retirees of Texas Option Plus (Must live outside the Limited Network Services Area but in Texas.)

☐ I OPT-OUT OF MEDICAL COVERAGE. I understand that I may re-enroll in the future.

Dental Plan – Policy# 709543 (select one):
☐ Indemnity Plan – PVRC – 0001
☐ DHMO Plan – PVRC – 0013

Dental Coverage Type:
☐ Retiree/Survivor Only
☐ Retiree/Survivor + 1 Dependent
☐ Retiree/Survivor + 2 or More Dependents

☐ I OPT-OUT OF DENTAL COVERAGE. I understand that I may re-enroll in the future.

BLOCK VISION
Vision Coverage Type:
☐ Retiree/Survivor Only
☐ Retiree + Spouse
☐ Retiree/Survivor + Child(ren)
☐ Retiree + Spouse + Child(ren)

☐ I OPT-OUT OF VISION COVERAGE. I understand that I may re-enroll in the future.

B. Complete the following for each person that will be covered under the plan you selected.

| Last Name | First Name | MI | Medical Add'l Prem | Dental Add'l Prem | Vision Add'l Prem | Social Security No. | Date of Birth | Relationship (Circle One) | $25 Monthly Charge for Tobacco Users Tobacco User (Yes / No) |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | SELF | Yes / No |
| | | | | | | | | SPOUSE | Yes / No |
| | | | | | | | | SON / DAUGHTER | Yes / No |
| | | | | | | | | SON / DAUGHTER | Yes / No |

C. Complete this section to show your Cigna KelseyCare ID of #667709011, or Renaissance, or Mayor Healthcare Group Primary Care Physician (PCP) and DHMO Dentist ID numbers, as required for person(s) in Section B.

| Person (Circle One) | Male ✓ | Female ✓ | Last Name, First, M.I. | Primary Care Physician No. | DHMO Dentist ID # |
|---|---|---|---|---|---|
| Retiree | | | | | |
| Husband/Wife | | | | | |
| Child/Stepchild/Grandchild | | | | | |
| Child/Stepchild/Grandchild | | | | | |
| Child/Stepchild/Grandchild | | | | | |

NOTE: An Eligible Dependent means your legal spouse, and any child (natural, adopted, foster, grandchild, stepchild, a child for whom you are legal guardian and to have legal support obligations) who is your dependent for federal income tax purposes, resides with you (except in the case of a court order), and is under age 26. A dependent may be your child who is 26 or older, financially supported by you, and incapable of self-sustaining employment by reason of mental, physical disability or handicap which arose while the child was covered as a dependent under this Plan, or while covered as a dependent under a prior City plan without a break in coverage. Proof of the child's condition and dependence must be submitted within 31 days after the child ceases to qualify.

Relationship documents: certified marriage certificate, Registration and Declaration of an Informal Marriage certificate (common law), legal and court order documents, and official birth certificates or birth facts, as appropriate.

D. Authorization of Deductions From Pension Check

I am a retiree or survivor of the City of Houston, eligible to participate in the Health Benefits Program. I apply to make the above coverage election and understand that information I have provided is part of my application. All statements made by me may be relied upon by the City, if any information that I have provided is found to be materially incorrect, my coverage may be denied. I realize that coverage my dependents are eligible for at this time, which I drop, may not be available until the next open enrollment, unless I provide proof of a change in family status within 31 days of the family status change. I agree that if I have listed ineligible dependent, I may incur a monetary penalty and/or my medical coverage may be canceled. If I waive coverage for which I or my dependent are eligible, I will not be eligible for coverage in the future. I authorize the pension system to deduct from my pension check my portion of the contribution as it becomes due.

I understand that I may notify the City of Houston when I have an ineligible dependent and that I may not receive a refund of contributions paid for an ineligible dependent. I will be responsible for medical claims paid on an ineligible dependent. All plan provisions will apply to my dependent.

| Date | Contact Phone Number | Signature |
|---|---|---|
| | | |

WHITE – Benefits BLUE – Medicare Plan GOLD – Retiree Rev. 02/14

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**PDF fillable forms are available at www.cityofhoustonbenefits.org**

# For assistance, contact:

Phone: 832-393-6000

Fax: 832-395-9409

retireebenefits@houstontx.gov

611 Walker, 4th Floor

Houston, TX 77002

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