Enrolling in Health Insurance Benefits at Retirement Class

What's In Your Health Insurance Packet?

Your packet is divided into Right and Left Sides

Left Side of Packet

- Cover Letter
- Employee Summary of Benefits Form
- Premium Cost Share Form(s)
- 2024 Health and Life Insurance Retiree Election Form
- Retiree Cost Share Election Form
- Application for Retiree Health Insurance Benefits

  Only for members of the RSP, GRIP, or MD State Retirement Plans

What's In Your Health Insurance Packet? (cont.)

Your packet is divided into Right and Left Sides

Left Side of Packet

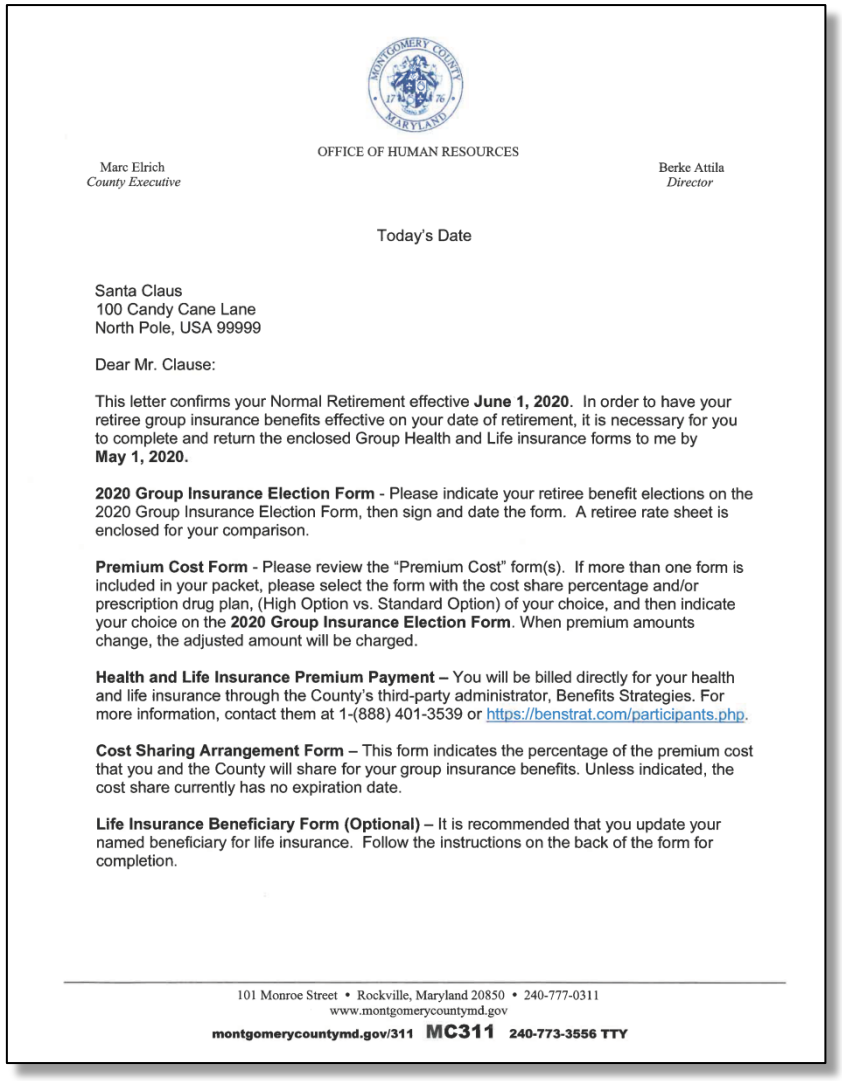
- Medicare Enrollment Information Letter - Only if Medicare Eligible
- Medicare "Request for Employment Information" Form – Only if Medicare Eligible
- MD State Summary of Benefits Form – Only if MD State Retirement
  - MD State 2024 Retiree Election Form
  - MD State Rate Sheet
  - MD State Beneficiary Forms
- Kaiser Medicare Plus Enrollment Form – Only if Age 65
- 2024 Retirement Calendar
- Life Insurance Beneficiary Form

What's In Your Health Insurance Packet? (cont.)

Your packet is divided into Right and Left Sides.

Right Side of Packet

- Retiree Monthly Rate Sheet
- Vision Options for Employees at Retirement
- Caremark Standard Option Prescription Benefit Plan
- EyeMed Insight Discount Vision ID Card
- EyeMed Retiree Vision Plan Chart
- Important Benefits Contact Information
- Retiree Change of Address or Name Form
- MCREA Membership Letter and Application Form



OFFICE OF HUMAN RESOURCES

Marc Elrich
County Executive

Berke Attila
Director

Today's Date

Santa Claus
100 Candy Cane Lane
North Pole, USA 99999

Dear Mr. Clause:

This letter confirms your Normal Retirement effective **June 1, 2020**. In order to have your retiree group insurance benefits effective on your date of retirement, it is necessary for you to complete and return the enclosed Group Health and Life insurance forms to me by **May 1, 2020.**

2020 Group Insurance Election Form - Please indicate your retiree benefit elections on the 2020 Group Insurance Election Form, then sign and date the form. A retiree rate sheet is enclosed for your comparison.

Premium Cost Form - Please review the "Premium Cost" form(s). If more than one form is included in your packet, please select the form with the cost share percentage and/or prescription drug plan, (High Option vs. Standard Option) of your choice, and then indicate your choice on the **2020 Group Insurance Election Form**. When premium amounts change, the adjusted amount will be charged.

Health and Life Insurance Premium Payment – You will be billed directly for your health and life insurance through the County's third-party administrator, Benefits Strategies. For more information, contact them at 1-(888) 401-3539 or https://benstrat.com/participants.php.

Cost Sharing Arrangement Form – This form indicates the percentage of the premium cost that you and the County will share for your group insurance benefits. Unless indicated, the cost share currently has no expiration date.

Life Insurance Beneficiary Form (Optional) – It is recommended that you update your named beneficiary for life insurance. Follow the instructions on the back of the form for completion.

101 Monroe Street • Rockville, Maryland 20850 • 240-777-0311
www.montgomerycountymd.gov
montgomerycountymd.gov/311 **MC311** 240-773-3556 TTY

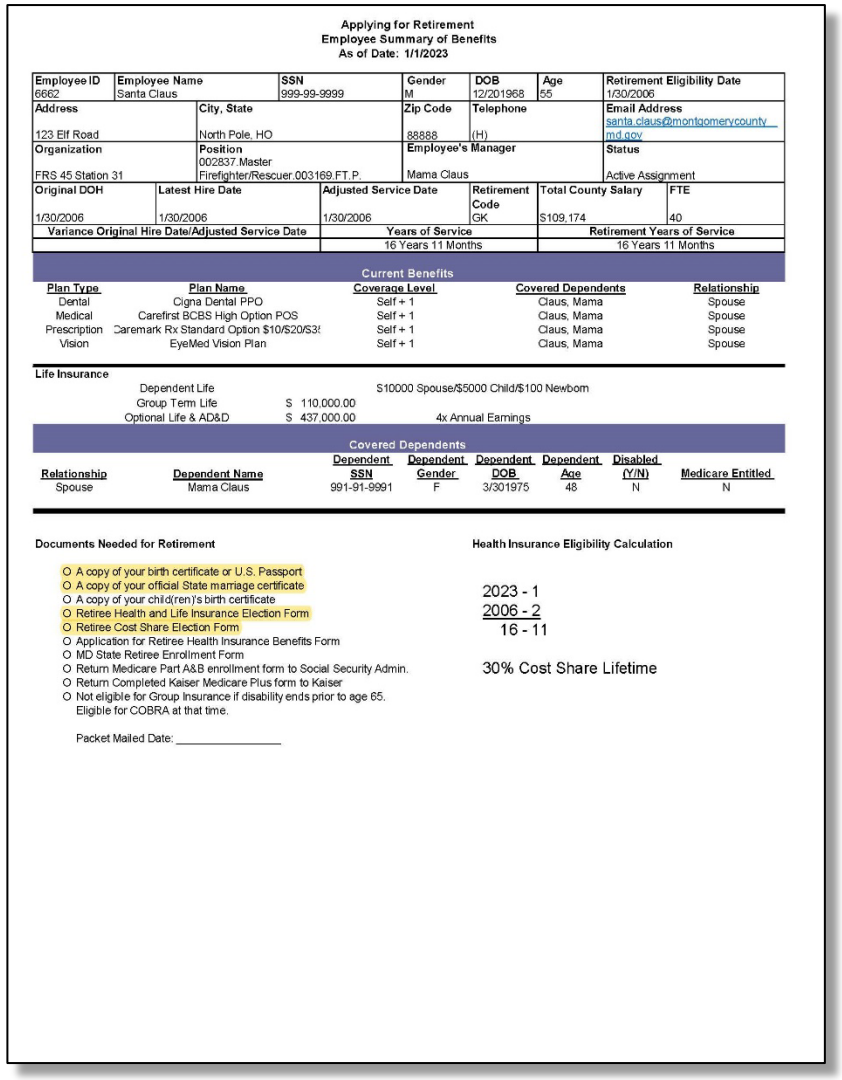
Enrolling in Health Insurance Benefits at Retirement

Office of Human Resources, Montgomery County Government

Cover Letter

Please read your cover letter carefully and pay close attention to the following:

- Deadline that your completed forms must be returned to OHR,
- Billing for Health and Life Insurance Premiums,
- Medicare Eligibility,
- Legal Documents that must be returned with your completed forms, and
- Contact Information for the OHR Health Insurance Specialist



Applying for Retirement
Employee Summary of Benefits
As of Date: 1/1/2023

Employee ID	Employee Name	SSN	Gender	DOB	Age	Retirement Eligibility Date
6662	Santa Claus	999-99-9999	M	12/201968	55	1/30/2006

Address	City, State	Zip Code	Telephone	Email Address
123 Elf Road	North Pole, HO	88888	(H)	santa.claus@montgomerycountymd.gov

Organization	Position	Employee's Manager	Status
FRS 45 Station 31	002837.Master Firefighter/Rescuer.003169.FT.P.	Mama Claus	Active Assignment

Original DOH	Latest Hire Date	Adjusted Service Date	Retirement Code	Total County Salary	FTE
1/30/2006	1/30/2006	1/30/2006	GK	$109,174	40

Variance Original Hire Date/Adjusted Service Date	Years of Service	Retirement Years of Service
	16 Years 11 Months	16 Years 11 Months

Current Benefits

Plan Type	Plan Name	Coverage Level	Covered Dependents	Relationship
Dental	Cigna Dental PPO	Self + 1	Claus, Mama	Spouse
Medical	Carefirst BCBS High Option POS	Self + 1	Claus, Mama	Spouse
Prescription	Caremark Rx Standard Option $10/$20/$3	Self + 1	Claus, Mama	Spouse
Vision	EyeMed Vision Plan	Self + 1	Claus, Mama	Spouse

Life Insurance

Dependent Life		$10000 Spouse/$5000 Child/$100 Newborn
Group Term Life	$ 110,000.00	
Optional Life & AD&D	$ 437,000.00	4x Annual Earnings

Covered Dependents

Relationship	Dependent Name	Dependent SSN	Dependent Gender	Dependent DOB	Dependent Age	Disabled (Y/N)	Medicare Entitled
Spouse	Mama Claus	991-91-9991	F	3/301975	48	N	N

Documents Needed for Retirement

- O A copy of your birth certificate or U.S. Passport
- O A copy of your official State marriage certificate
- O A copy of your child(ren)'s birth certificate
- O Retiree Health and Life Insurance Election Form
- O Retiree Cost Share Election Form
- O Application for Retiree Health Insurance Benefits Form
- O MD State Retiree Enrollment Form
- O Return Medicare Part A&B enrollment form to Social Security Admin.
- O Return Completed Kaiser Medicare Plus form to Kaiser
- O Not eligible for Group Insurance if disability ends prior to age 65. Eligible for COBRA at that time.

Packet Mailed Date: _____

Health Insurance Eligibility Calculation

2023 - 1
2006 - 2
16 - 11

30% Cost Share Lifetime

Enrolling in Health Insurance Benefits at Retirement

Office of Human Resources, Montgomery County Government

Employee Summary of Benefits Form

This form is an overview of your demographics, current health and life insurance benefit elections, and a list of dependents that you currently cover on your health insurance plans.

- On the bottom left side of this form is a list of “Documents Needed for Retirement”
- On the bottom right side of this form is the Health Insurance Eligibility Calculation” used to determine the percentage of the insurance premium that you will pay.

Documents Required to Prove Eligibility

Please Provide 1 Copy of the required documents listed below even if previously provided:

- **Retiree:** State certified birth certificate, or U.S. Passport, or DD-214 (military discharge form) for identification purposes.

If Electing Group Insurance Coverage for a Dependent:

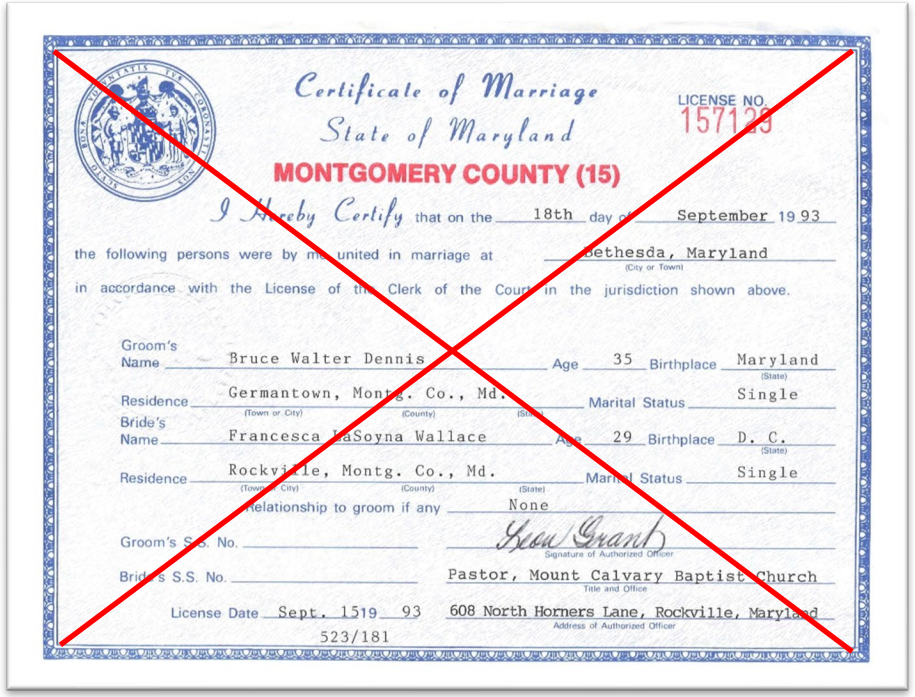
- **Spouse**: Official State Marriage Certificate (must be signed by the appropriate State or County official, such as the Clerk of the Court),
- **Domestic Partner**: The Domestic Partner Affidavit Form submitted to OHR prior to 2016.
- **Child** to age 26: Proof of child's age (official State birth certificate).

- **IMPORTANT NOTE:** Marriage certificates signed by the officiant that performed the ceremony (e.g. minister/clergy) will not be accepted. A Driver's License or Social Security card will not be accepted.

Go to: www.vitalchek.com to order the required documents that you are unable to locate.

Proof of Eligibility (cont.)

Official State Marriage Certificate (certified by appropriate State or County Official)



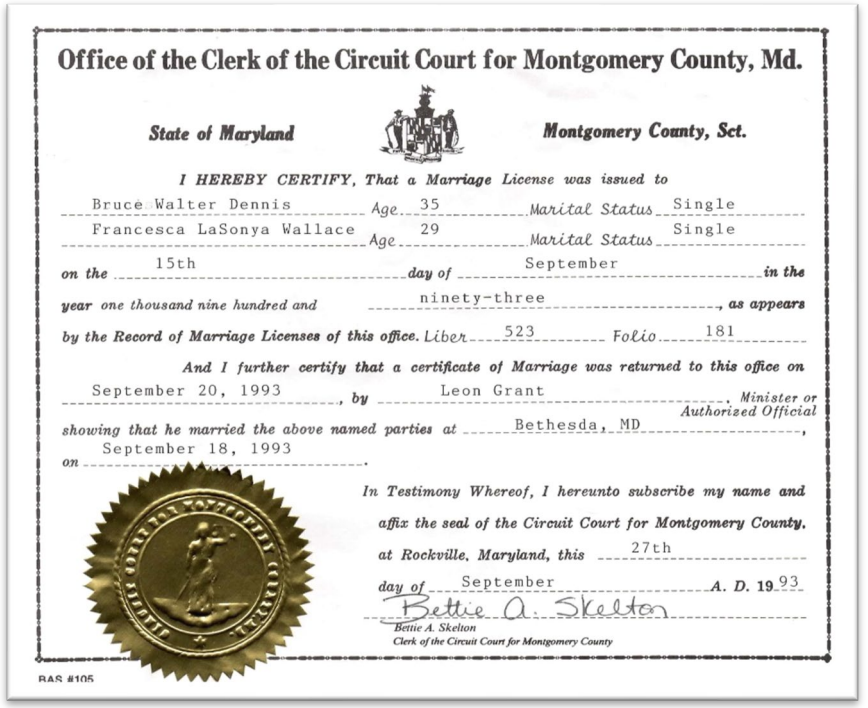
Certificate of Marriage
State of Maryland
LICENSE NO. 157125
MONTGOMERY COUNTY (15)

I Hereby Certify that on the 18th day of September 19 93
the following persons were by me united in marriage at Bethesda, Maryland (City or Town)
in accordance with the License of the Clerk of the Court in the jurisdiction shown above.

Groom's Name: Bruce Walter Dennis — Age 35 — Birthplace Maryland (State)
Residence: Germantown, Montg. Co., Md. (Town or City) (County) (State) — Marital Status Single
Bride's Name: Francesca LaSoyna Wallace — Age 29 — Birthplace D. C. (State)
Residence: Rockville, Montg. Co., Md. (Town or City) (County) (State) — Marital Status Single
Relationship to groom if any: None

Groom's S.S. No.
Bride's S.S. No.
Leon Grant
Signature of Authorized Officer
Pastor, Mount Calvary Baptist Church
Title and Office
License Date Sept. 15 19 93
608 North Horners Lane, Rockville, Maryland
Address of Authorized Officer
523/181

Not Acceptable



Office of the Clerk of the Circuit Court for Montgomery County, Md.

State of Maryland — Montgomery County, Sct.

I HEREBY CERTIFY, That a Marriage License was issued to

Bruce Walter Dennis — Age 35 — Marital Status Single
Francesca LaSonya Wallace — Age 29 — Marital Status Single

on the 15th *day of* September *in the year one thousand nine hundred and* ninety-three, *as appears by the Record of Marriage Licenses of this office. Liber* 523 *Folio* 181

And I further certify that a certificate of Marriage was returned to this office on September 20, 1993, *by* Leon Grant, *Minister or Authorized Official showing that he married the above named parties at* Bethesda, MD, *on* September 18, 1993.

In Testimony Whereof, I hereunto subscribe my name and affix the seal of the Circuit Court for Montgomery County, at Rockville, Maryland, this 27th *day of* September *A. D. 19* 93

Bettie A. Skelton
Bettie A. Skelton
Clerk of the Circuit Court for Montgomery County

BAS #105

Acceptable

Office of Human Resources
Montgomery County Government
Premium Cost Share

Employee ID: Z100000 **Name:** Santa Claus

Date of Retirement: 06-01-2020
Normal Retirement Date: N/A
Total Membership Years: 12 years 11 months

Salary: $98,813.00
Adj Salary: N/A (for IAFF and FOP only)

Life Insurance:

Based on Active Life Insurance of $99,000.00
Basic Life Insurance at Retirement $59,400.00 ($99,000.00 * 12 yrs * .05)
The basic amount will never go lower than $14,850.00
Optional Life Insurance at Retirement $99,000.00 (100% * $99,000.00 * 1)
The optional amount will never go lower than $24,750.00

Basic Life			Optional Life		
* $59,400.00	06-01-2020		$99,000.00	06-01-2020	
* $14,850.00	12-20-2023	- At age 65	$49,500.00	12-20-2028	- At age 70
			$24,750.00	12-20-2033	- At age 75

Group Insurance: 20% UNTIL 04-30-2033 THEN 100% 2020 Rates

* $	217.95	Health	CareFirst High Option Employee+1
* $	16.47	Dental	Dental PPO - Cigna Employee+1
* $	0.00	Vision	Discount Vision Employee+1
* $	77.35	Rx	Caremark Standard Option $10/$20/$35 Employee+1
* $	3.96	Life Insurance (Non contributory at Age 65)	
* $	44.25	Optional Life Additional 1 Times Salary	
* $	0.32	Dep Life $2,000/$1,000	

Your premium will be $360.30 (subject to future adjustments)

NOTE - Retirees are not eligible for active vision care, however retirees may maintain this coverage through COBRA

Office of Human Resources
Montgomery County Government
Premium Cost Share

Employee ID: Z100000 **Name:** Santa Claus

Date of Retirement: 06-01-2020
Normal Retirement Date: N/A
Total Membership Years: 12 years 11 months

Salary: $98,813.00
Adj Salary: N/A (for IAFF and FOP only)

Life Insurance:

Based on Active Life Insurance of $99,000.00
Basic Life Insurance at Retirement $59,400.00 ($99,000.00 * 12 yrs * .05)
The basic amount will never go lower than $14,850.00
Optional Life Insurance at Retirement $99,000.00 (100% * $99,000.00 * 1)
The optional amount will never go lower than $24,750.00

Basic Life			Optional Life		
* $59,400.00	06-01-2020		$99,000.00	06-01-2020	
* $14,850.00	12-20-2023	- At age 65	$49,500.00	12-20-2028	- At age 70
			$24,750.00	12-20-2033	- At age 75

Group Insurance: 30% LIFETIME COSTSHARE 2020 Rates

* $	326.92	Health	CareFirst High Option Employee+1
* $	24.71	Dental	Dental PPO - Cigna Employee+1
* $	0.00	Vision	Discount Vision Employee+1
* $	464.29	Rx	Caremark Hi Option $5/$10 Employee+1
* $	5.93	Life Insurance (Non contributory at Age 65)	
* $	44.25	Optional Life Additional 1 Times Salary	
* $	0.48	Dep Life $2,000/$1,000	

Your premium will be $866.58 (subject to future adjustments)

NOTE - Retirees are not eligible for active vision care, however retirees may maintain this coverage through COBRA

Imputed Income

For Basic Life Insurance Above $50,000

- Imputed income affects the amount of Basic Life Insurance above $50,000.
- If you receive County-provided Basic life insurance with a value equal to or greater than $50,000 in any given year, the value of the coverage is considered imputed income and is taxable income,
- The County will send you a form W-2 every year that your Basic Life insurance value is above $50,000
- For more information, visit: http://www.montgomerycountymd.gov/HR/Resources/Files/Benefits/Imputed_Income_Retiree_BasicLife.pdf

How Do I Pay My Monthly Insurance Premiums?

Members of the Employees' Retirement System (ERS): Your health insurance premiums are deducted directly from your monthly pension paychecks. If there are not enough funds to cover the health insurance premiums, the member is direct billed as described below.

Members of the Retirement Savings Plan (RSP), Guaranteed Retirement Income Plan (GRIP), or MD State: You are billed directly for your health insurance through the County's third-party administrator, Voya Financial. Voya Financial will also send COBRA notices for the EyeMed vision plan. Expect a coupon book the 1st week of the month that you retire. For more information, contact them at 1-888-401-3539 or www.voya.com.

All insurance premiums are paid on an after-tax basis.

2024 Health and Life Insurance
RETIREE - Election Form

RETIREE INFORMATION

Use this form for initial insurance enrollment or for an eligible qualifying event. Upload required documentation by clicking the attachment icon (paperclip) to the left or the bottom of the page.

Retiree SSN: ______ Retiree Date of Birth: ______ Gender: ☐ Male ☐ Female

Retiree Name: ______

Street Address: ______

City, State, ZIP Code: ______

Telephone Home #: ______ Cell #: ______

Email Address: ______

*Your email address will not be shared and will **only be** used by OHR to contact the retiree regarding their health insurance.*

Medical Plan (choose one)

Medicare Part B is required when you or your covered dependents become entitled to Medicare. You must provide a copy of your Medicare card to OHR.

- ☐ No Medical coverage
- ☐ Kaiser HMO (includes Prescription)
- ☐ United HealthCare HMO
- ☐ CareFirst POS High Option
- ☐ CareFirst POS Standard Option

Dental Plan (choose one)

- ☐ No Dental coverage
- ☐ Dental PPO (traditional dental plan)

Vision Plan

- ☐ Discount Vision
- ☐ Fully Insured Vision
- ☐ No Vision

Prescription / Rx Plan (choose one)

For Kaiser and Indemnity plan participants, no Rx election is needed as Rx coverage is included in your plan

- ☐ No Prescription coverage
- ☐ Standard Option Rx plan

Optional Life Insurance (choose one)

- ☐ Cancel Optional Life Coverage
- ☐ Keep Current Optional Life Coverage

Dependent Life Insurance (choose one)

- ☐ Cancel Dependent Life Coverage
- ☐ Keep Current Dependent Life Coverage

DEPENDENT COVERAGE

To change dependent coverage, complete the section below and **upload copies of the required documentation** (e.g., birth certificate, adoption certificate, marriage certificate, etc.). Note that you must elect the same coverage for yourself in the medical, prescription, dental and/or vision sections of this form (e.g., your dependent may not have the vision plan unless you do). Also, the number of dependents you cover under each plan will determine your coverage level (Self, Self+1 or Family) and your cost for each plan.

☐ Add Eligible Dependent(s) ☐

Check if Dependent is also an MCG Employee	NAME OF ELIGIBLE DEPENDENT	SOCIAL SECURITY NUMBER *(Required)*	DATE OF BIRTH	SEX M F	RELATIONSHIP	INSURANCE ELECTIONS (Choose All that Apply)
☐				☐ ☐	○ Spouse ○ Child	☐ Medical ☐ Dental ☐ Rx ☐ Vision
☐				☐ ☐	○ Spouse ○ Child	☐ Medical ☐ Dental ☐ Rx ☐ Vision
☐				☐ ☐	○ Spouse ○ Child	☐ Medical ☐ Dental ☐ Rx ☐ Vision
☐				☐ ☐	○ Spouse ○ Child	☐ Medical ☐ Dental ☐ Rx ☐ Vision
☐				☐ ☐	○ Spouse ○ Child	☐ Medical ☐ Dental ☐ Rx ☐ Vision

☐ Delete / Disenroll Dependent(s)

FULL NAME OF DEPENDENT	NO LONGER ELIGIBLE	COVERAGE TO BE CANCELLED (Choose All that Apply)
	☐	☐ Medical ☐ Dental ☐ Rx ☐ Vision
	☐	☐ Medical ☐ Dental ☐ Rx ☐ Vision

SIGNATURE

I have read the materials available for the County's Group Insurance Plan. I authorize the County to make a deduction from my ERS or LTD2 benefit for my insurance elections. If I pay directly for insurance, I will promptly pay the cost or benefits will terminate. I understand that the County may adjust my elections. I authorize the release of enrollment information to the extent necessary to properly administer my elections. I understand that electing benefits to which I or any other person is not entitled is considered fraud and if I misrepresent my eligibility or that of any other person, or fail to take the steps necessary to remove ineligible persons, or in any way obtain benefits to which I am not entitled, benefits will terminate. In addition, I must repay any claims which have been paid inappropriately, and I may face charges. I understand that the County expects to continue the Plan, but it is the County's position that there is no implied contract between members and the County to do so. I also understand that the County reserves the right at any time and for any reason to amend the Plan, subject to any applicable County's collective bargaining agreements. The County may also amend the Plan, prospectively or retroactively to comply with applicable law.

➪ **Signature:** ______ **Date:** ______

Comments : ______

Reminder: Upload any required documentation and Medicare cards before submitting your form. If you/covered dependent have not yet received your Medicare cards, be sure to provide a copy via the methods below as soon as you are in receipt:

Mail: OHR Health Insurance Team, 101 Monroe St., 7th Floor, Rockville, MD 20850
Fax: 240-777-5131 (include fax/mail cover sheet)
Email: OHR.HITS@montgomerycountymd.gov (please only send via encrypted email for security reasons)

8/22/23

2024 Health and Life Insurance Retiree – Election Form

Please complete your Retiree Election Form thoroughly to ensure accurate processing.

- If selecting a plan, check the box next to the plan name.
- If waiving a plan, check the "No Coverage" box for that plan.
- You may only *decrease* the value of your Optional Life policy prior to submitting retirement forms.
- If you are not currently enrolled in Optional Life or Dependent Life plans, you are not eligible for either as a retiree.

Add All Eligible Dependents

- If you plan to continue coverage for an eligible dependent, each dependent ***must*** be added to the "Dependent Coverage" section on the back of the form, even if the dependent is currently covered.
- If the "Dependent Coverage" section is left blank, then none of your dependents will be covered.
- Sign and Date the form.

Retiree Insurance Election Form

FOR EMPLOYEES HIRED ON OR AFTER JANUARY 1, 1987

COST SHARING ARRANGEMENT
FOR MEDICAL AND DENTAL PREMIUMS AT RETIREMENT

Initials

_____ ☐ I understand that the premium sharing arrangement will be 70% County paid and 30% paid by me.

I understand that when I become eligible for Medicare benefits I must apply for both Part A and Part B.

I understand that the County expects to continue the retiree benefit plans, but assumes no contractual obligation to do so. I also understand that the County reserves the right at any time and for any lawful reason to amend the retiree benefit plans. Further, I understand that the County may amend the retiree benefit plans at any time, either prospectively or retroactively, to conform to the Internal Revenue Code.

I understand that if I currently have Vision and /or Healthcare Flexible Spending Account, I will be offered continuation of coverage through COBRA.

I understand that I may retain optional and dependent life insurance as a retiree. Retiree optional and dependent life coverages may not be increased or decreased after retirement, only maintained or cancelled.

I understand that I am authorizing the County to either deduct my premiums from any pension or disability payments. If these payments are not sufficient, or I do not receive any payments from the County, I will be responsible for paying my premiums directly to the County's third party administrator.

Santa Claus _____ Z100000 _____
Name Employee ID

_____ _____
Signature **Date**

Retiree Insurance Election Form

FOR EMPLOYEES HIRED PRIOR TO JANUARY 1, 1987

COST SHARING ARRANGEMENT
FOR MEDICAL AND DENTAL PREMIUMS AT RETIREMENT

Initials

_____ ☐ I elect the cost sharing arrangement of 80% County paid/ 20% paid by me. I understand that as of 05-01-2033, I will be required to pay 100% of the premium to maintain coverage.

_____ ☐ I elect the cost sharing arrangement of 70% County paid / 30% paid by me. I understand that this cost sharing arrangement currently has no expiration date.

I understand that when I become eligible for Medicare benefits I must apply for both Part A and Part B.

I understand that the County expects to continue the retiree benefit plans, but assumes no contractual obligation to do so. I also understand that the County reserves the right at any time and for any lawful reason to amend the retiree benefit plans. Further, I understand that the County may amend the retiree benefit plans at any time, either prospectively or retroactively, to conform to the Internal Revenue Code.

I understand that I may retain optional and dependent life insurance as a retiree. Retiree optional and dependent life coverages may not be increased or decreased after retirement, only maintained or cancelled.

I understand that I am authorizing the County to either deduct my premiums from any pension or disability payments. If these payments are not sufficient, or I do not receive any payments from the County, I will be responsible for paying my premiums directly to the County's third party administrator.

Santa Claus _____ Z100000 _____
Name Employee ID

_____ _____
Signature **Date**

Retiree Cost Share Election Form

Please initial and check the box for the cost sharing arrangement that you agree to have with the County for your lifetime. Please sign and date that you have read and understood the information provided to you in this document.

Office of Human Resources

Montgomery County Government

Application for Retiree Health Insurance Benefits

For Members of the :

- **Retirement Savings Plan (RSP)**
- **Guaranteed Retirement Income Plan (GRIP)**
- **State of Maryland Retirement Plans**

Name: _____ Retirement Plan Code: _____

SSN: _____ Date of Hire: _____

Address: _____ Gender: _____

_____ Date of Birth: _____

_____ Phone Number: _____

This is my application for normal retirement to be effective on _____.
I certify that I meet the criteria for retirement from the Plan and that the information on this form is true and correct to the best of my knowledge.

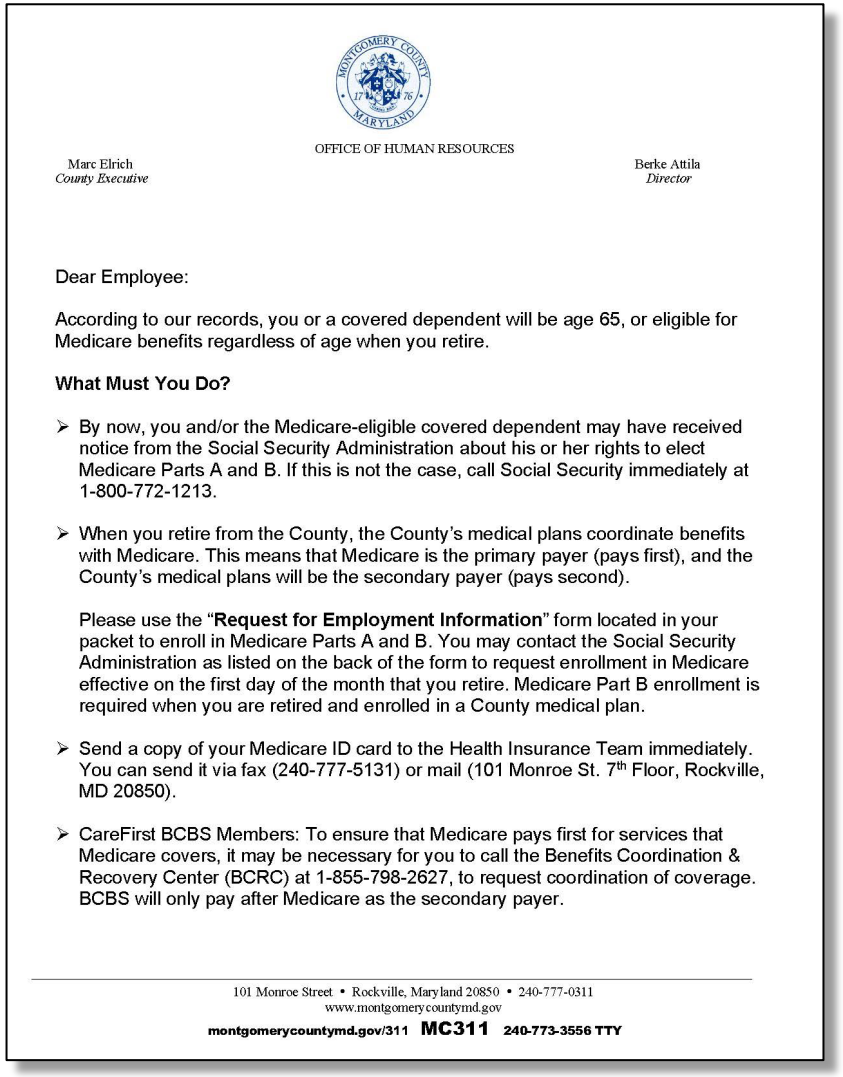
_____

Member's Signature Date

Application for Retiree Health Insurance Benefits Form

This form confirms your request to separate from the County and to continue the health and life insurance benefits offered to members of the RSP, GRIP, and MD State retirement plans.

Please complete the highlighted areas of the form, then sign and date to confirm that your retirement date is the effective date listed on the form.



OFFICE OF HUMAN RESOURCES

Marc Elrich
County Executive

Berke Attila
Director

Dear Employee:

According to our records, you or a covered dependent will be age 65, or eligible for Medicare benefits regardless of age when you retire.

What Must You Do?

- By now, you and/or the Medicare-eligible covered dependent may have received notice from the Social Security Administration about his or her rights to elect Medicare Parts A and B. If this is not the case, call Social Security immediately at 1-800-772-1213.
- When you retire from the County, the County's medical plans coordinate benefits with Medicare. This means that Medicare is the primary payer (pays first), and the County's medical plans will be the secondary payer (pays second).

  Please use the "**Request for Employment Information**" form located in your packet to enroll in Medicare Parts A and B. You may contact the Social Security Administration as listed on the back of the form to request enrollment in Medicare effective on the first day of the month that you retire. Medicare Part B enrollment is required when you are retired and enrolled in a County medical plan.
- Send a copy of your Medicare ID card to the Health Insurance Team immediately. You can send it via fax (240-777-5131) or mail (101 Monroe St. 7th Floor, Rockville, MD 20850).
- CareFirst BCBS Members: To ensure that Medicare pays first for services that Medicare covers, it may be necessary for you to call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627, to request coordination of coverage. BCBS will only pay after Medicare as the secondary payer.

101 Monroe Street • Rockville, Maryland 20850 • 240-777-0311
www.montgomerycountymd.gov
montgomerycountymd.gov/311 **MC311** 240-773-3556 TTY

Enrolling in Health Insurance Benefits at Retirement

Office of Human Resources, Montgomery County Government

Medicare Cover Letter

Only in your packet if you or a covered dependent is Medicare eligible.

Please follow the instructions that are outlined in your “cover letter” to enroll either you or your covered dependent in Medicare, effective on the date of your retirement.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0787

REQUEST FOR EMPLOYMENT INFORMATION

SECTION A: To be completed by individual signing up for Medicare Part B (Medical Insurance)

1. Employer's Name: Montgomery County Government
2. Date: ☐☐ / ☐☐ / ☐☐☐☐
3. Employer's Address: 101 Monroe Street, 7th Floor
City: Rockville
State: MD
Zip Code: 20906
4. Applicant's Name:
5. Applicant's Social Security Number: ☐☐☐ – ☐☐ – ☐☐☐☐
6. Employee's Name:
7. Employee's Social Security Number: ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION B: To be completed by Employers

For Employer Group Health Plans ONLY:

1. Is (or was) the applicant covered under an employer group health plan? ☒ Yes ☐ No
2. If yes, give the date the applicant's coverage began. (mm/yyyy) ☐☐ / ☐☐☐☐
3. Has the coverage ended? ☐ Yes ☒ No
4. If yes, give the date the coverage ended. (mm/yyyy) ☐☐ / ☐☐☐☐
5. When did the employee work for your company?
From: (mm/yyyy) ☐☐ / ☐☐☐☐
To: (mm/yyyy) ☐☐ / ☐☐☐☐
Still Employed: (mm/yyyy) ☐☐ / ☐☐☐☐
6. If you're a large group health plan and the applicant is disabled, please list the timeframe (all months) that your group health plan was primary payer.
From: (mm/yyyy) ☐☐ / ☐☐☐☐
To: (mm/yyyy) ☐☐ / ☐☐☐☐

For Hours Bank Arrangements ONLY:

1. Is (or was) the applicant covered under an Hours Bank Arrangement? ☐ Yes ☒ No
2. If yes, does the applicant have hours remaining in reserve? ☐ Yes ☐ No
3. Date reserve hours ended or will be used? (mm/yyyy) ☐☐ / ☐☐☐☐

All Employers:

Signature of Company Official:
Date Signed: ☐☐ / ☐☐ / ☐☐☐☐
Title of Company Official: Health Insurance Specialist
Phone Number: (240) 777 – 5080

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0787. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, MD 21244-1850.

Form CMS L564/R297 (08/20) 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-1230
Expires: 02/20

APPLICATION FOR ENROLLMENT IN MEDICARE PART B (MEDICAL INSURANCE)

1. Your Medicare Number
2. Do you wish to sign up for Medicare Part B (Medical Insurance)? ☐ YES
3. Your Name (Last Name, First Name, Middle Name)
4. Mailing Address (Number and Street, P.O. Box, or Route)
5. City
State: ☐☐
Zip Code: ☐☐☐☐☐
6. Phone Number (including area code)
(☐☐☐) ☐☐☐ – ☐☐☐☐
7. Written Signature (DO NOT PRINT)
SIGN HERE
8. Date Signed: ☐☐ / ☐☐ / ☐☐☐☐

IF THIS APPLICATION HAS BEEN SIGNED BY MARK (X), A WITNESS WHO KNOWS THE APPLICANT MUST SUPPLY THE INFORMATION REQUESTED BELOW.

9. Signature of Witness
10. Date Signed: ☐☐ / ☐☐ / ☐☐☐☐
11. Address of Witness
12. Remarks
I want Part B to begin: ☐☐ / 01 / ☐☐☐☐

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1230. The time required to complete this information is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

CMS-40B (04/19) 2

Enrolling in Health Insurance Benefits at Retirement

Office of Human Resources, Montgomery County Government

Request for Employment Information Form

Only in your packet if you or a covered dependent is Medicare eligible.

Please follow the instructions that are outlined in your letter to enroll either you or your covered dependent in Medicare, effective on the date of your retirement.

Please return this form along with your "Application For Part B Enrollment Form" to the Social Security Administration to enroll in Medicare Part A and/or Part B effective on the date of your retirement.

On the "Application For Part B Enrollment Form", write "I want Part B coverage to begin (MM/YY)" in the remarks section of the CMS-40B form or online application.

What Is Medicare?

- **Part A (Hospital Insurance)** covers most medically necessary hospital, skilled nursing facility, home health and hospice care. It is free if you have worked and paid Social Security taxes for at least 40 calendar quarters (10 years); you will pay a monthly premium if you have worked and paid taxes for less time.
- **Part B (Medical Insurance)** covers 80% of most medically necessary doctors' services, preventive care, durable medical equipment, hospital outpatient services, laboratory tests, x-rays, mental health care, and some home health and ambulance services. You pay a monthly premium for this coverage and it is required if you want to receive benefits from your County medical plan.
  - ***Without Part B, member will be responsible for approximately 80% of claim costs that Part B would have covered.***
  - ***You cannot continue in the Kaiser plan unless you elect Part B and enroll in the Kaiser Medicare Plus Plan.***
- **Part D** (**Prescription**) is required if enrolled in the County's prescription drug plan. The County's prescription plan works together with Medicare Part D to maintain your current coverage level; this process is administered through SilverScript.
  - **Enrollment in Part D is automatic. You should not elect a separate Medicare Part D plan if enrolled in the County's prescription plan.**
  - **SilverScript does not apply to Kaiser participants.**

When Do You Need to Apply?

Medicare Parts A and B

- **Active Employees** and their covered dependents do not need to enroll in Medicare Parts A or B when they become eligible due to age (65) or disability (at any age). Your County medical plan will continue as primary coverage, for as long as you are an active employee.
- **Retiring Employees** and/or their covered dependents who are eligible for Medicare due to age (65) or disability (at any age), when you retire, will be given the "Request for Employment Information" Medicare form (CMS-L564) to enroll in Medicare Parts A and B effective on your retirement date. At that time, Medicare Parts A and B becomes primary and the County's medical plan becomes a secondary policy to Medicare.
- **Retired Employees and Their Covered Dependents Approaching age 65** should contact the Social Administration three months prior to their 65th birthday, to initiate enrollment in Medicare Parts A and B. The County will send a courtesy letter to retirees and their eligible spouse, reminding you to enroll in Medicare Parts A and B. Medicare enrollment must be effective on the first day of the month that you and your spouse turn age 65. At that time, Medicare Parts A and B becomes primary and the County's medical plan becomes a secondary policy to Medicare.

IMPORTANT: If you or your covered dependents do not apply for Medicare when eligible, you may be charged premium penalties assessed by the Social Security Administration.

Medicare Parts B and D Premiums are based on income

If your filing status and "Adjusted Gross Income" in 2022 was…

Your "Adjusted Gross Income" is located on line 11 on your Form 1040.

Individual Tax Return	Joint Tax Return	You Pay Part B each month (2024)	You Pay Part D each month (2024)
$103,000 or less	$206,000 or less	**$174.70**	Your Plan Premium
above $103,000 up to $129,000	above $206,000 up to $258,000	$244.60	$12.90 + Your plan premium
above $129,000 up to $161,000	above $258,000 up to $322,000	$349.40	$33.30 + Your plan premium
above $161,000 up to $193,000	above $322,000 up to $386,000	$454.20	$53.80 + Your plan premium
above $193,000 and less than $500,000	above $386,000 and less than $750,000	$559.00	$74.20 + Your plan premium
$500,000 or above	$750,000 and above	$594.00	$81.00 + Your plan premium

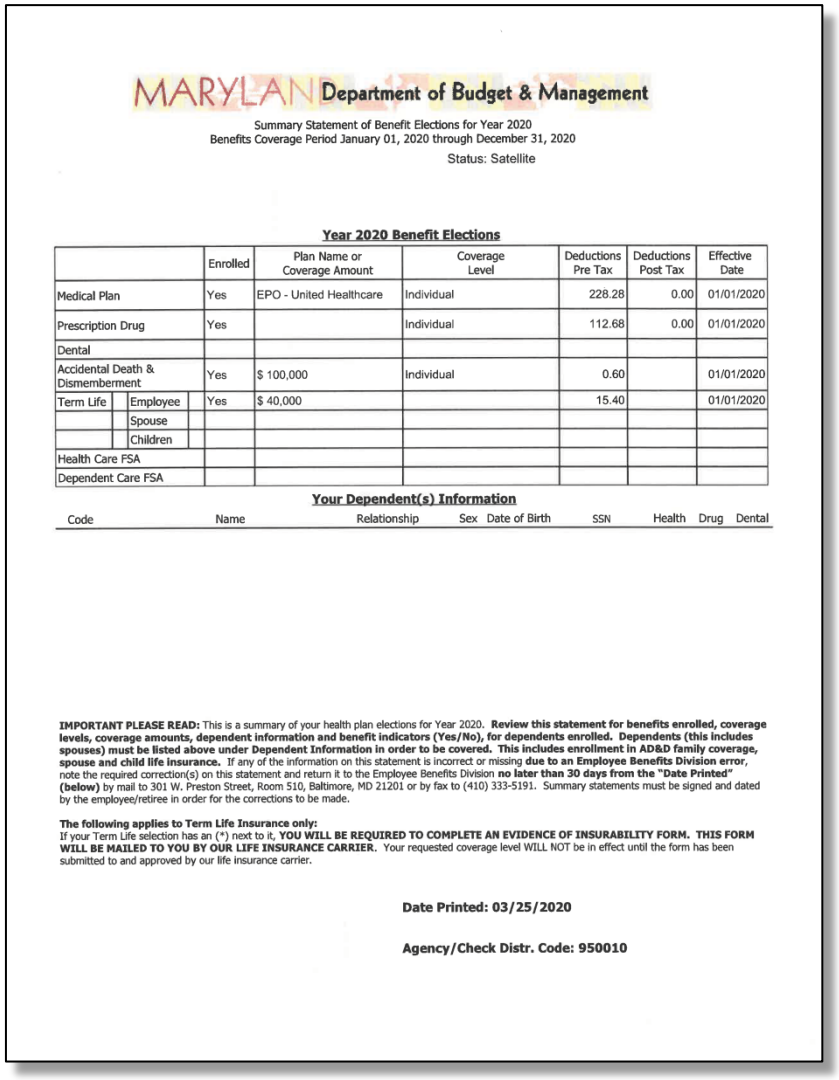
Does Your Doctor Accept Medicare?

The County's retiree group insurance benefits coordinate with Medicare. That means once a retiree or a retiree's dependent becomes eligible for Medicare (at age 65 for most), the County's plans will only pay secondary to Medicare.

This same concept also applies to physicians that choose not to participate with Medicare. The County's plan does not pay as the primary insurance in situations where your physician or therapist doesn't participate with Medicare.

When you transition to Medicare, you'll want to make sure that your current physicians accept Medicare. If they do not, you can continue to see them, but be aware that the County's plan will not cover costs that should be paid for by Medicare, for example:

	Office Visit	Paid by Medicare	Paid by County Group Plan	Paid by Retiree
Enrolled in Medicare	$100.00	$80.00	$20.00	$0.00
NOT Enrolled in Medicare	$100.00	$0.00	$20.00	$80.00



MARYLAND Department of Budget & Management

Summary Statement of Benefit Elections for Year 2020
Benefits Coverage Period January 01, 2020 through December 31, 2020
Status: Satellite

Year 2020 Benefit Elections

		Enrolled	Plan Name or Coverage Amount	Coverage Level	Deductions Pre Tax	Deductions Post Tax	Effective Date
Medical Plan		Yes	EPO - United Healthcare	Individual	228.28	0.00	01/01/2020
Prescription Drug		Yes		Individual	112.68	0.00	01/01/2020
Dental							
Accidental Death & Dismemberment		Yes	$ 100,000	Individual	0.60		01/01/2020
Term Life	Employee	Yes	$ 40,000		15.40		01/01/2020
	Spouse						
	Children						
Health Care FSA							
Dependent Care FSA							

Your Dependent(s) Information

Code	Name	Relationship	Sex	Date of Birth	SSN	Health	Drug	Dental

IMPORTANT PLEASE READ: This is a summary of your health plan elections for Year 2020. **Review this statement for benefits enrolled, coverage levels, coverage amounts, dependent information and benefit indicators (Yes/No), for dependents enrolled. Dependents (this includes spouses) must be listed above under Dependent Information in order to be covered. This includes enrollment in AD&D family coverage, spouse and child life insurance.** If any of the information on this statement is incorrect or missing **due to an Employee Benefits Division error,** note the required correction(s) on this statement and return it to the Employee Benefits Division **no later than 30 days from the "Date Printed" (below)** by mail to 301 W. Preston Street, Room 510, Baltimore, MD 21201 or by fax to (410) 333-5191. Summary statements must be signed and dated by the employee/retiree in order for the corrections to be made.

The following applies to Term Life Insurance only:
If your Term Life selection has an (*) next to it, **YOU WILL BE REQUIRED TO COMPLETE AN EVIDENCE OF INSURABILITY FORM. THIS FORM WILL BE MAILED TO YOU BY OUR LIFE INSURANCE CARRIER.** Your requested coverage level WILL NOT be in effect until the form has been submitted to and approved by our life insurance carrier.

Date Printed: 03/25/2020

Agency/Check Distr. Code: 950010

Enrolling in Health Insurance Benefits at Retirement

Office of Human Resources, Montgomery County Government

Maryland Department of Budget & Management

Only in your packet if you will receive a MD State pension.

Please complete and return to OHR the following MD State forms in your packet:

- MD State 2024 Retiree Election Form
- MD State Beneficiary Forms

Your MD State benefit election premiums will be deducted from your State monthly pension payment.

You will continue to participate in the State's Open Enrollment period each year.

KAISER PERMANENTE®

Group Plan

Kaiser Permanente Medicare Advantage (HMO)

Enrollment form

Mid-Atlantic States Region Group Plan

Filling out and returning the enrollment form is your first step to becoming a Kaiser Permanente Medicare Advantage member. If you and your spouse are both applying, you'll each need to fill out a separate form. For help completing the enrollment form, call our Member Services at **1-888-777-5536** (TTY **711**), seven days a week, 8 a.m. to 8 p.m.

How to fill out this form

1. Answer all questions and print your answers using black or blue ink. Fill in check boxes with an X.
2. Sign the form on page 4 and date it. **Make sure you've read all the pages before you sign.**
3. Mail the original, signed form to:
   Kaiser Permanente – Medicare Unit
   P.O. Box 232407
   San Diego, CA 92193-9914
4. Make a copy for your records. If required, submit a copy to your employer group, union or trust fund.

Next steps

- We'll review your form to make sure it's complete. Then we'll let you know by mail that we've received it.
- We'll let Medicare know that you've applied for Medicare Advantage.
- Within 10 calendar days after Medicare confirms your enrollment, we'll first let you know the start date for your coverage. Next, we will send you a Kaiser Permanente ID card and your new member package within 10 days of your start date.

To check on the status of your application, please visit **kp.org/medicare/applicationstatus**.

Kaiser Medicare Plus Enrollment Form
Complete if Kaiser is your medical plan and you or a covered dependent is either age 65 or Medicare Eligible.

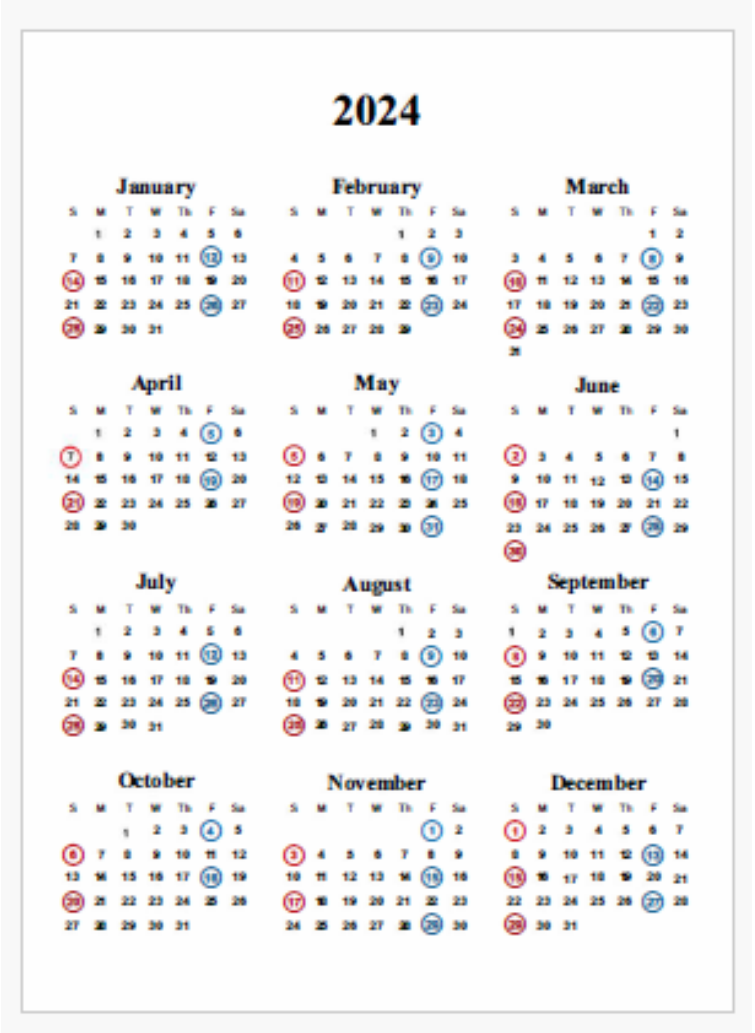
Follow these instructions to enroll in the Kaiser Medicare Plus plan online, once your Medicare ID card arrives:

- Got to www.kp.org/medicare
- Click on “Search by employer/group name.”
- Choose the Region “Maryland/Virginia/Washington DC”
- Enter “Montgomery County Government”
- Enter “Group #” 3012-200

You cannot continue in the Kaiser plan unless you elect Medicare Part B and enroll in the Kaiser Medicare Plus plan.

Feel free to contact Kaiser should you have questions about how the Kaiser Medicare Plus plan works at 301-468-6000 or 1-800-777-7902.

2024 Retirement Calendar



2024 Retirement Calendar

Please review the 2024 Retirement Calendar and pay close attention to the “Packet Due!” date. This is date that your completed packet must be returned to OHR.

Note: All Health and Life insurance deductions will be deducted from your “Full” and “Partial” pays.

LIFE INSURANCE BENEFICIARY DESIGNATION/CHANGE FORM

Please fill out each section completely and use additional forms if necessary.
This Beneficiary Designation/Change form applies to **ALL** life insurance coverages offered under my employer's plan.

1. Employee Information ***(PLEASE PRINT CLEARLY USING BLACK INK)***

First Name	MI	Last Name	Social Security Number

Address	City	State	Zip Code

2. Beneficiary Designations: I hereby revoke any previous designations of primary and contingent beneficiary(ies), if any, and designate the following:

A. Primary Beneficiary(ies) -

Beneficiary Description (check one)	First Name	MI	Last Name	Address (include city, state, zip code)	Relationship/DOB	Social Security Number	% Share
☐ Individual ☐ Corporation/Organization ☐ Trust ☐ Other_____ ☐ My Estate							
☐ Individual ☐ Corporation/Organization ☐ Trust ☐ Other_____ ☐ My Estate							
☐ Individual ☐ Corporation/Organization ☐ Trust ☐ Other_____ ☐ My Estate							

Total must equal 100% _____ %

If a minor child is named as a beneficiary: _____ (Guardian) **as custodian for** _____ (Child's Name) **under the** _____ (State) **State Uniform Transfers to Minors Act.**

B. Contingent Beneficiary(ies) -

Beneficiary Description (check one)	First Name	MI	Last Name	Address (include city, state, zip code)	Relationship/DOB	Social Security Number	% Share
☐ Individual ☐ Corporation/Organization ☐ Trust ☐ Other_____ ☐ My Estate							
☐ Individual ☐ Corporation/Organization ☐ Trust ☐ Other_____ ☐ My Estate							
☐ Individual ☐ Corporation/Organization ☐ Trust ☐ Other_____ ☐ My Estate							

Total must equal 100% _____ %

3. Trust Designation – Please attach a copy of the Trust Agreement. Complete if a Trust has been named as a beneficiary in Section 2.

Trustee's Name (First, MI, Last)	Address (include city, state, zip code)

And successor(s) in trust, as Trustee(s) under _____ (Title of Agreement) **dated** _____ (Date of Agreement) **as amended and executed by me and said Trustee.**

_____ _____

Signature ***Date***

➢ **Employee must sign and date this form. The signature date must be the date the employee actually signed the form.**

Rev. 6/2016

Life Insurance Beneficiary Form

Please complete the Life Insurance Beneficiary form, and return the white copy to OHR:

- Life Insurance Beneficiary Form – All employees

This form may be returned after the "Packet Due" deadline and updated at any time.

2024 Retiree Monthly Rate Sheet

30% Cost Share

RETIREE GROUP INSURANCE MONTHLY RATES
30.00% Cost Share
Effective January 1, 2024

HEALTH PLANS	Non-Medicare Self 30.00%	Non-Medicare Self + 1 30.00%	Non-Medicare Family 30.00%	Medicare Only Self 30.00%	Medicare Only Self + 1 30.00%	Medicare Only Family 30.00%	Non-Medicare & Medicare Split[1] Self + 1 30.00%	Non-Medicare & Medicare Split[1] Family 30.00%
MEDICAL:								
CareFirst High Option POS (medical only)	$ 225.63	$ 390.31	$ 657.20	$ 121.58	$ 225.33	$ 250.54	$ 286.26	$ 553.15
CareFirst Standard Option POS (medical only)	$ 209.84	$ 362.98	$ 611.20	$ 113.07	$ 209.56	$ 233.00	$ 266.22	$ 514.43
UnitedHealthcare Select HMO (medical only)	$ 184.70	$ 355.06	$ 564.44	$ 99.52	$ 202.96	$ 322.11	$ 269.88	$ 479.27
Kaiser HMO (medical with Rx)	$ 229.86	$ 432.15	$ 680.40	$ 101.79	$ 203.59	$ 305.38	$ 304.08	$ 552.33
CareFirst Indemnity (medical with Rx discount)[2]	$ 387.56	$ 825.47	$ 1,238.27	$ 200.11	$ 416.60	$ 516.53	$ 638.01	$ 1,050.81
PRESCRIPTION:								
Caremark Standard Option $10/$20/$35	$ 82.82	$ 153.22	$ 237.44	N/A	N/A	N/A	$ 170.28	$ 254.50
SilverScript Standard Option $10/$20/$35	N/A	N/A	N/A	$ 99.89	$ 199.78	$ 299.66	$ 170.28	$ 254.50
DENTAL:								
Dental PPO (Traditional Dental Plan)	$ 12.87	$ 28.67	$ 41.26	$ 12.87	$ 28.67	$ 41.26	$ 28.67	$ 41.26
VISION:								
Opti-Vision Discount Plan	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Vision Insured Plan	$ 0.82	$ 1.56	$ 2.42	$ 0.82	$ 1.56	$ 2.42	$ 1.56	$ 2.42

LIFE INSURANCE**	
Dependent Life Insurance	
$2,000/$1,000	$0.283
$4,000/$2,000	$1.751
$10,000/$5,000	$4.377
Basic Term Life Insurance	
per $1,000 coverage	$0.089

Optional Life Insurance per $1,000 coverage	
Age	100% Monthly Rates
<25	$0.049
25-29	$0.056
30-34	$0.069
35-39	$0.078
40-44	$0.084
45-49	$0.118
50-54	$0.172
55-59	$0.310
60-64	$0.466
65-69	$0.884
70-74	$1.564
75-79	$2.011
80-84	$2.011
85-89	$2.011
90-94	$2.011
95+	$2.011

To determine your total monthly premium, enter the costs for each of your plans

Medical	$ _____
Prescription	$ _____
Dental	$ _____
Vision	$ _____
Basic Life[3]	$ _____
Dep Life[3]	$ _____
Opt Life[3]	$ _____
TOTAL	$ 0.00

1 Non-Medicare and Medicare Split rates apply when (at least) one member is Medicare eligible and (at least) one member is non-Medicare eligible. Proof of under age 65 Medicare is required.

2 Only available to retirees who are currently enrolled in the CareFirst BCBS Indemnity Plan (closed to new members). Standard Option Prescription (Rx) plan is not available to Indemnity Plan participants.

3 Basic Life only available to eligible retirees (not surviving dependents). Optional and Dependent Life insurance are only available to Retirees who had coverage as of the day prior to retirement. Optional and Dependent Life can only be maintained or cancelled completely. Retiree Optional Life Insurance available after age 69 only for individuals who retired on or after January 1, 2016.

EyeMed Discount Vision ID Card

Benefit Questions?
Carrier Contact Information

Always call your provider first if you are experiencing an issue with your plan.

Office of Human Resources

Important Benefits Contact Information

Resource	Phone	Web / Email
Medical		
• CareFirst BlueCross BlueShield	1-888-417-8385	www.carefirst.com *Tip:* Go to Find a Provider, click the Search feature, and choose a doctor from any BlueChoice Advantage network.
• Kaiser Permanente		
○ *Washington area*	301-468-6000	https://myhealth.kaiserpermanente.org/montgomerycountygovernment/
○ *Baltimore area*	1-800-777-7902	
• UnitedHealthcare HMO	1-800-638-0014	http://welcometouhc.com/mcg or www.myuhc.com *Tip:* This plan utilizes the Select EPO network
Prescription		
• Caremark	1-866-240-4926	www.caremark.com
• SilverScript (Medicare-eligible retirees)	1-866-249-6167	www.mcg.silverscript.com
Dental		
• CIGNA	1-800-244-6224	www.cigna.com
Vision		
• EyeMed	1-866-800-5457	www.eyemed.com *Network: Insight*
Life, AD&D, Optional Life and LTD1		
• MetLife	1-800-638-6420	www.metlife.com http://www.lifeonlinecalculator.com/ *Life Insurance Needs Calculator*
Flexible Spending Accounts		
• Benefit Strategies/Voya	1-888-401-3539	https://benstrat.com/participants_fsa.php (general) https://benstrat.navigatorsuite.com (account access)
Direct Bill and COBRA		
• Benefit Strategies	1-888-401-3539	https://benstrat.com/participants.php
Voluntary Benefits		
• Aflac	1-202-558-5142	www.aflac.com
General Information		
• MC311 OHR Customer Service Center	240-777-0311	www.mc311.com Open Monday to Friday, 7 a.m. to 7 p.m. Any questions MC311 representatives cannot answer are immediately routed via a service request to the OHR Health Insurance Customer Care Center, Monday to Friday, open 8 a.m. to 5 p.m.
• Medicare	1-800-633-4227	www.medicare.gov
• Office of Human Resources (OHR) Health Insurance Team		Fax: 240-777-5131 (Fax) Mail: OHR Health Insurance Team 101 Monroe Street, 7th Floor Rockville, MD 20850
• Social Security Administration	1-800-772-1213	www.ssa.gov

Revised 01/05/2023

How to Contact Us

If your provider cannot answer your health insurance question, please contact MC311.

Monday to Friday, 7 a.m. to 7 p.m.

Speak with a Customer Service Representative at MC311.

Call 240-777-0311; TTY: 711; email: www.montgomerycountymd.gov/mc311

Any questions MC311 cannot answer are immediately routed via a service request to the OHR Health Insurance Customer Care Center, open Monday through Friday, 8 a.m. to 4 p.m.

How to Contact Us (cont.)

Retiree Health Insurance "Virtual Office Hours" Monthly
1st Thursday of the month From 3 - 4 pm via Zoom

The OHR Health Insurance Team is available the first Thursday of every month from 3 to 4 pm to answer any insurance benefit questions you or your dependents may have.

Follow these steps to register and attend the Virtual Zoom Office Hours:

1. Advance registration is required. Register to attend the monthly Zoom meeting at www.montgomerycountymd.gov/HI.
2. After you register, you will receive an email with a Zoom link to join the meeting.
3. Click on the Zoom link at any time during the hour (1st Thursday of the month from 3 to 4 pm) to join the meeting.
4. You will need to register again each month that you would like to attend.

Changing Your Benefit Elections

Retirees may make changes to their health insurance benefits (medical, prescription, dental and vision) at any time during the year:

Follow these steps:

1. Submit a Retiree Election Form with your changes to the Health Insurance Team by the 10th day of the month.
2. You may access the Retiree Election Form by selecting the link below.
   Montgomery County, MD 2024 Retiree Election Form (montgomerycountymd.gov)
3. Your change will take effect on the first day of the following month.

Changes due to a **Qualified Life Event**: You have 60 days from the date of the event to notify OHR of your qualified life event. Examples of a qualified life event include:

- Marriage, Divorce, Death of a dependent
- Spouse's loss of coverage under another plan
- Moving out of your plan's eligibility area

Changes for life events are effective when all completed paperwork is received by OHR.

Returning to Work for the County

In the event that you return to work for the County after retirement

- Your retiree group insurance benefits will continue, and you will pay the same premium cost share that you paid when you retired.
- You will participate in active group life insurance during your period of re-employment. You may elect benefits which are not offered to retirees, such as the dental DHMO, employee vision plan, and the FSA.
- When you again leave County employment, your participation in the retiree group insurance program continues with the life insurance amount in effect at the time you originally retired, subject to any reductions which would have occurred during your time of re-employment.

Moving Out of State?

Kaiser is not available nationwide, so participants must elect either United Healthcare or one of the CareFirst BCBS POS Plans (High or Standard Option). Also, because Kaiser includes prescription drug coverage, Kaiser participants must elect one of the separate Caremark Prescription Plans (High or Standard Option).

The **CareFirst BlueCross BlueShield (BCBS) Point-of-Service (POS) plan offers a nationwide network** called the "BlueChoice Advantage POS Network." It provides in and out-of-network benefits if you reside inside or outside the POS network service area. Participants use a national "BlueCard EPO/PPO Network" provider for services considered outside the POS network service area.

United Healthcare is available nationwide, so participants do not need to do anything to continue the same coverage.

IMPORTANT: Any changes to your health insurance must be made within 60 days of your move by completing:

1. Retiree Health Insurance Election Form www.montgomerycountymd.gov/hr
2. Retiree Change of Address Form www.montgomerycountymd.gov/MCERP

In the Event of Your Death after Retirement

In the event of your death, your spouse will be offered the option to remain on the County's health insurance plan for the rest of his or her life.

The cost share percentage that you choose when you retire remains the same for your surviving spouse and eligible dependents.

Your surviving spouse may only cover other dependents who were eligible for coverage at the time of your death, including an unborn child.

Returning Your Completed Forms

The following forms must be completed and return to OHR by the deadline:

1. 2024 Health and Life Insurance Retiree Election Form
2. Retiree Cost Share Election Form
3. Application for Retiree Health Insurance Benefits – RSP, GRIP, or MD State
4. Beneficiary Form
5. MD State 2024 Retiree Enrollment Form - MD State Retirees Only
6. MD State Beneficiary Forms – MD State Retirees Only

You may use the self-addressed envelope enclosed in your packet to mail or hand deliver the required forms to OHR, by the deadline. Only send copies of birth certificates, U.S. Passports, and marriage certificates.

Returning Your Completed Forms (cont.)

Return the following form(s) to Kaiser once enrolled in Medicare Part B. Use the Kaiser envelope provided:

1. Kaiser Medicare Plus Enrollment Form – If Age 65 or Medicare Eligible (at any age)

Return the following form(s) to The Social Security Administration to enroll in Medicare Part B.

1. Request for Employment Information Form (CMS-L564) – If age 65 or Medicare Eligible (at any age)

If Medicare eligible, Medicare Part B must be effective on the 1st day of your Retirement for full coverage.

Returning Your Completed Forms (cont.)

Return All Leave Payout Forms to the Payroll Department:

8th Floor EOB
101 Monroe Street, Rockville, MD 20850
financepayroll@montgomerycountymd.gov

Please submit the form that corresponds to where your Deferred Compensation account is (Empower or Fidelity). The forms are available at Payroll (sharepoint.com) under Applications/Forms.

Employees in the RSP or GRIP Retirement plans are eligible to be paid for unused Sick Leave as follows:

- Employees with at least 10 years of service and a sick leave balance of at least 120 hours are eligible to receive a $5,000 payout.
- Employees with at least 20 years of service and a sick leave balance of least 240 hours are eligible to receive a $10,000 payout.

Employees who are members of the IAFF Fire Bargaining Unit are eligible to be paid for 176 hours of unused sick leave.

Do not return Leave Payout Forms to OHR.

LUMP SUM ANNUAL/COMP LEAVE PAYOUT FORM

For Deposit into the County's 457 Deferred Compensation Plan (Fidelity)

Complete this form and return it to:

Payroll Department

8th Floor EOB,
101 Monroe Street, Rockville, MD 20850
payroll@montgomerycountymd.gov

Please print or type the following information:

Name	Date of Birth
Address	Social Security Number _____ – _____ – _____
City	State, Zip Code
Phone Home ( ) – Cell ( ) –	Email

I elect to have $ _____ (indicate dollars and not hours of leave) of my Lump Sum Annual/ Comp Leave Payout deposited into my Montgomery County Deferred Compensation Plan account from my _____ final leave pay out check.
(Enter check date)

Termination/Retirement Date: _____

I understand that the amount I have elected cannot exceed the total number of dollars allowed under Federal Law. I further understand that any funds not able to be deposited into my Montgomery County Deferred Compensation Plan account will be direct deposited, if authorized, or a check will be sent to my address of record. I understand that the Plan will not be held responsible for any tax penalties that may occur for an incomplete submission.

I agree to the terms of the Montgomery County Deferred Compensation Plan. I acknowledge that I have received and reviewed a prospectus for the mutual funds in which I am investing and that I understand the potential risks associated with these investments.

Participant's Signature: _____ **Date:** _____

Note: This allocation will not affect any current or future investment elections. If you wish to make changes to current or future investment elections, you will need to call 1-800-343-0860.

YES

INCREASE MY CONTRIBUTION.

For assistance call 1-800-743-5274, Monday – Friday, 8 a.m. – 9 p.m. ET and speak with an Empower specialist or go online at www.massmutual.com/mcuedcp. Your contribution increase will begin as soon as administratively feasible following Empower's receipt of this postcard.

Change my current contribution to:

O $25 O $50 O $75 O Other $ _____ O Other % _____

O Pre-tax O Roth

First and Last Name: _____

Last 4 of SSN or Empl# _____

Address: _____

City/State/Zip: _____

Signature: _____

Termination/Retirement Date: _____

62384

Annual/Comp LEAVE PAYOUT FORM to:
d.pounds@empower-retirement.com
payroll@montgomerycountymd.gov

Do not return Leave Payout Forms to OHR.

Insurance Benefits Reminders

- You are responsible for your benefits.
- Read the materials provided in your retirement packet.
- Reissued *New* ID Card for BCBS only. Receive new ID card mid-month.
- Voya Financial coupon book mailed 1st of month that you retire.
- Review insurance deductions billed monthly by Voya Financial.
- Review insurance deductions on your monthly pension check.
- Mail or Fax a copy of Medicare Part B ID card(s) to OHR.
- Call Medicare to Coordinate Benefits at 1-855-798-2627, when primary payer.
- SilverScript ID cards are mailed 4 months after OHR receives Medicare B.
- Read the materials mailed to your home and let us know if you move.

Legal Information

The County expects to continue its health insurance plans, but it is the County's position that there is no implied contract between employees and the County to do so, and the County reserves the right at any time and for any reason to amend the terms of the plans or terminate the plans, subject to the County's collective bargaining agreements. The County may also amend the plans at any time, either prospectively or retroactively, as required by federal law.