

# **Enrolling in Health Insurance Benefits at Retirement Class**



Office of Human Resources, Montgomery County Government

# 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)
- 2025 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



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government

# 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 2025 Retiree Election Form
  - MD State Rate Sheet
  - MD State Beneficiary Form
- Kaiser Medicare Plus Enrollment Form – [Only if Age 65](#)
- 2025 Retirement Calendar
- Life Insurance Beneficiary Form



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government

# **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
- Caremark Standard Option Prescription Benefit Plan
- EyeMed Insight Discount Vision ID Card
- EyeMed Retiree Vision Plan Comparison Chart
- Important Benefits Contact Information
- Retiree Change of Address or Name Form
- MCREA Membership Letter and Application Form



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government





OFFICE OF HUMAN RESOURCES

Marc Elrich  
County Executive

Traci L. Anderson  
Director

Today's Date

Santa Claus  
123 Elf Road  
North Pole, HO 88888

Dear Mr. Claus:

This letter confirms your Normal Retirement effective **December 1, 2025**. To have your retiree group insurance benefits effective on your date of retirement, it is necessary for you to complete and return the attached Group Health and Life insurance forms to me by **November 7, 2024**.

**2025 Group Insurance Election Form** - Please indicate your retiree benefit elections on the 2025 Group Insurance Election Form, then sign and date the form. A retiree rate sheet is attached 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 of your choice. 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, Voya Financial. For more information, contact them at 1-(888) 401-3539 or [www.voya.com](http://www.voya.com).

**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](http://www.montgomerycountymd.gov)

[montgomerycountymd.gov/311](http://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



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government

**Applying for Retirement  
Employee Summary of Benefits  
As of Date: 12/1/2025**

Employee ID 15390	Employee Name Claus, Santa	SSN 999-999-9999	Gender M	DOB 12/09/2086	Age 59	Retirement Eligibility Date 6/10/2005
Address 123 Elf Road		City, State North Pole, HO	Zip Code 88888	Telephone (H)	Email Address santa.claus@montgomerycountymd.gov	
Organization DOT 50 Highway Services		Position 004128 Equipment Operator 1,005113.FT P.	Employee's Manager Mama Clause		Status Active Assignment	
Original DOH 6/10/2005	Latest Hire Date 6/10/2005	Adjusted Service Date 6/10/2005	Retirement Code RM	Total County Salary \$70,000	FTE 40	
Variance Original Hire Date/Adjusted Service Date		Years of Service 20 Years 6 Months		Retirement Years of Service 20 Years 6 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/\$30	Self + 1	Claus, Mama	Spouse
Vision	EyeMed Vision Plan	Self + 1	Claus, Mama	Spouse

<b>Life Insurance</b>	
Dependent Life	\$2000 Spouse/\$1000 Child/\$100 Newborn
Group Term Life	\$ 70,000.00

Covered Dependents						
Relationship	Dependent Name	Dependent SSN	Dependent Gender	Dependent DOB	Dependent Age	Medicare Entitled
Spouse	Claus, Mama	991-91-9991	F	9/19/1966	59	N

<b>Documents Needed for Retirement</b>  <input type="checkbox"/> A copy of your birth certificate or U.S. Passport <input type="checkbox"/> A copy of your official State marriage certificate <input type="checkbox"/> A copy of your child(ren)'s birth certificate <input type="checkbox"/> Retiree Health and Life Insurance Election Form <input type="checkbox"/> Retiree Cost Share Election Form <input type="checkbox"/> Application for Retiree Health Insurance Benefits Form <input type="checkbox"/> MD State Retiree Enrollment Form <input type="checkbox"/> Return Medicare Part A&B enrollment form to Social Security Admin. <input type="checkbox"/> Return Completed Kaiser Medicare Plus form to Kaiser <input type="checkbox"/> Not eligible for Group Insurance if disability ends prior to age 65. Eligible for COBRA at that time.  Packet Mailed Date: _____	<b>Health Insurance Eligibility Calculation</b>  2025 - 12 2005 - 6 20 - 6  30% Cost Share Lifetime
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# 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.



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government

# 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](http://www.vitalchek.com) to order the required documents that you are unable to locate.



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government

# Proof of Eligibility (cont.)

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

**Certificate of Marriage**  
State of Maryland  
**MONTGOMERY COUNTY (15)**

I *Hereby* Certify that on the 18th day of September 1993  
the following persons were by me united in marriage at Bethesda, Maryland  
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  
Residence Germantown, Montg. Co., Md. Marital Status Single  
Bride's Name Francesca LaSonya Wallace Age 29 Birthplace D. C.  
Residence Rockville, Montg. Co., Md. Marital Status Single  
Relationship to groom if any None

Groom's S.S. No. \_\_\_\_\_  
Bride's S.S. No. \_\_\_\_\_  
License Date Sept. 15 19 93  
523/181

*Leon Grant*  
Signature of Authorized Officer  
Pastor, Mount Calvary Baptist Church  
Title and Office  
608 North Horners Lane, Rockville, Maryland  
Address of Authorized Officer

**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  
showing that he married the above named parties at Bethesda, MD Authorized Official,  
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. 1993  
*Bettie A. Skelton*  
Bettie A. Skelton  
Clerk of the Circuit Court for Montgomery County

RAS #105

**Acceptable**



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government

**Office of Human Resources  
Montgomery County Government  
Premium Cost Share**

Employee ID: 15390      Name: Santa Claus

Date of Retirement: 12-01-2025  
Normal Retirement Date: N/A  
Total Membership Years: 20 years 6 months

Salary: \$70,000.00  
Adj Salary: N/A (for IAFF and FOP only)

**Life Insurance:**

Based on Active Life Insurance of \$70,000.00  
Basic Life Insurance at Retirement \$70,000.00 (\$70,000.00 \* 20 yrs \* .05)  
The basic amount will never go lower than \$17,500.00  
Optional Life Insurance at Retirement \$210,000.00 (100% \* \$70,000.00 \* 3)  
The optional amount will never go lower than \$52,500.00

Basic Life		Optional Life	
* \$70,000.00	12-01-2025	\$210,000.00	12-01-2025
* \$63,000.00	12-01-2030	\$105,000.00	12-09-2036
* \$56,000.00	12-01-2031	\$52,500.00	12-09-2041
* \$17,500.00	12-09-2031	- At Age 65	- At age 75

Group Insurance: 20% UNTIL 05-31-2046 THEN 100% 2025 Rates

* \$	291.69	Health	CareFirst High Option Employee+1
* \$	19.54	Dental	Dental PPO - Cigna Employee+1
* \$	1.04	Vision	Vision Insured Plan Employee+1
* \$	114.30	Rx	Caremark Standard Option \$10/\$20/\$35 Employee+1
* \$	4.14	Life Insurance (Non contributory at Age 65)	
* \$	65.10	Optional Life Additional 3 Times Salary	
* \$	4.38	Dep Life \$10,000/\$5,000	

Your premium will be \$500.19 (subject to future adjustments)

NOTE - Retirees are not eligible for the active vision plan. This coverage may be maintained through COBRA.

**Office of Human Resources  
Montgomery County Government  
Premium Cost Share**

Employee ID: 15390      Name: Santa Claus

Date of Retirement: 12-01-2025  
Normal Retirement Date: N/A  
Total Membership Years: 20 years 6 months

Salary: \$70,000.00  
Adj Salary: N/A (for IAFF and FOP only)

**Life Insurance:**

Based on Active Life Insurance of \$70,000.00  
Basic Life Insurance at Retirement \$70,000.00 (\$70,000.00 \* 20 yrs \* .05)  
The basic amount will never go lower than \$17,500.00  
Optional Life Insurance at Retirement \$210,000.00 (100% \* \$70,000.00 \* 3)  
The optional amount will never go lower than \$52,500.00

Basic Life		Optional Life	
* \$70,000.00	12-01-2025	\$210,000.00	12-01-2025
* \$63,000.00	12-01-2030	\$105,000.00	12-09-2036
* \$56,000.00	12-01-2031	\$52,500.00	12-09-2041
* \$17,500.00	12-09-2031	- At Age 65	- At age 75

Group Insurance: 30% LIFETIME COSTSHARE 2025 Rates

* \$	437.54	Health	CareFirst High Option Employee+1
* \$	29.30	Dental	Dental PPO - Cigna Employee+1
* \$	1.56	Vision	Vision Insured Plan Employee+1
* \$	171.45	Rx	Caremark Standard Option \$10/\$20/\$35 Employee+1
* \$	6.22	Life Insurance (Non contributory at Age 65)	
* \$	65.10	Optional Life Additional 3 Times Salary	
* \$	4.38	Dep Life \$10,000/\$5,000	

Your premium will be \$715.55 (subject to future adjustments)

NOTE - Retirees are not eligible for the active vision plan. This coverage may be maintained through COBRA.



**Enrolling in Health Insurance Benefits at Retirement**  
Office of Human Resources, Montgomery County Government



# 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](http://www.montgomerycountymd.gov/HR/Resources/Files/Benefits/Imputed_Income_Retiree_BasicLife.pdf)



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government



# 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 1<sup>st</sup> week of the month that you retire. For more information, contact them at 1-888-401-3539 or [www.voya.com](http://www.voya.com).

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



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government



## 2025 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.

Check if Dependent is also an MCG Employee	Print All Eligible Dependent(s)	NAME OF ELIGIBLE DEPENDENT	SOCIAL SECURITY NUMBER (Required)	DATE OF BIRTH	SEX M F	RELATIONSHIP	INSURANCE ELECTIONS (Choose All that Apply)
<input type="checkbox"/>						<input type="radio"/> Spouse	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
<input type="checkbox"/>						<input type="radio"/> Child	<input type="checkbox"/> Rx <input type="checkbox"/> Vision
<input type="checkbox"/>						<input type="radio"/> Spouse	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
<input type="checkbox"/>						<input type="radio"/> Child	<input type="checkbox"/> Rx <input type="checkbox"/> Vision
<input type="checkbox"/>						<input type="radio"/> Spouse	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
<input type="checkbox"/>						<input type="radio"/> Child	<input type="checkbox"/> Rx <input type="checkbox"/> Vision
<input type="checkbox"/>						<input type="radio"/> Spouse	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
<input type="checkbox"/>						<input type="radio"/> Child	<input type="checkbox"/> Rx <input type="checkbox"/> Vision
<input type="checkbox"/>						<input type="radio"/> Spouse	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
<input type="checkbox"/>						<input type="radio"/> Child	<input type="checkbox"/> Rx <input type="checkbox"/> Vision

☐ Delete / Disenroll Dependent(s)

FULL NAME OF DEPENDENT	NO LONGER ELIGIBLE	COVERAGE TO BE CANCELLED (Choose All that Apply)
	<input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
	<input type="checkbox"/>	<input type="checkbox"/> Rx <input type="checkbox"/> Vision
	<input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
	<input type="checkbox"/>	<input type="checkbox"/> Rx <input type="checkbox"/> 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)

9/5/2024



# Enrolling in Health Insurance Benefits at Retirement

Office of Human Resources, Montgomery County Government

# 2025 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.



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government

**Retiree Cost Share 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 or a covered dependent become eligible for Medicare due to age (65) or disability (regardless of age), enrollment in Medicare Parts A and B is required.

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  
Name

15390  
Employee ID

Signature

Date

**Retiree Cost Share 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 06-01-2046, 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 or a covered dependent become eligible for Medicare due to age (65) or disability (regardless of age), enrollment in Medicare Parts A and B is required.

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  
Name

15390  
Employee ID

Signature

Date



**Enrolling in Health Insurance Benefits at Retirement**  
Office of Human Resources, Montgomery County Government

# 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.



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government



## 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



# Enrolling in Health Insurance Benefits at Retirement

Office of Human Resources, Montgomery County Government

# **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.



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government



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. 7<sup>th</sup> 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](http://www.montgomerycountymd.gov)

[montgomerycountymd.gov/311](http://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.



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government

# 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 M D	Zip Code 2 0 9 0 6
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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
2. If yes, give the date the applicant's coverage began. (mm/yyyy) /		
3. Has the coverage ended? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
2. If yes, does the applicant have hours remaining in reserve? <input type="checkbox"/> Yes <input type="checkbox"/> 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 ( 2 4 0 ) 7 7 7 - 5 0 8 0	

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.



# 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.



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government

# 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.



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government

# 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 65<sup>th</sup> 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.*



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government

# Medicare Parts B and D Premiums are based on income

If your filing status  
and “Adjusted Gross  
Income” in 2024  
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 (2025)	You Pay Part D each month (2025)
\$105,000 or less	\$210,000 or less	<b>\$185.00</b>	Your Plan Premium
above \$105,000 up to \$131,000	above \$210,000 up to \$262,000	\$259.00	\$13.70 + Your plan premium
above \$131,000 up to \$163,000	above \$262,000 up to \$326,000	\$369.90	\$35.30 + Your plan premium
above \$163,000 up to \$196,000	above \$326,000 up to \$392,000	\$480.80	\$57.00 + Your plan premium
above \$196,000 and less than \$500,000	above \$392,000 and less than \$750,000	\$591.90	\$78.60 + Your plan premium
\$500,000 or above	\$750,000 and above	\$628.90	\$85.80 + Your plan premium



**Enrolling In Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government

# 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



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government

# 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 2025 Retiree Enrollment Form
- MD State Beneficiary Form

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.



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government



## 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](https://kp.org/medicare/applicationstatus).



## Enrolling in Health Insurance Benefits at Retirement

Office of Human Resources, Montgomery County Government

## **Kaiser Medicare Advantage Enrollment Form**

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

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

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



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government

# 2025 Retirement Calendar

2025

<b>January</b> S M T W Th F Sa 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	<b>February</b> S M T W Th F Sa 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28	<b>March</b> S M T W Th F Sa 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
<b>April</b> S M T W Th F Sa 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30	<b>May</b> S M T W Th F Sa 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	<b>June</b> S M T W Th F Sa 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
<b>July</b> S M T W Th F Sa 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	<b>August</b> S M T W Th F Sa 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	<b>September</b> S M T W Th F Sa 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
<b>October</b> S M T W Th F Sa 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	<b>November</b> S M T W Th F Sa 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30	<b>December</b> S M T W Th F Sa 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31



Enrolling in Health Insurance Benefits at Retirement  
Office of Human Resources, Montgomery County Government

# 2025 Retirement Calendar

Please review the 2025 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.



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government

### 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
<input type="checkbox"/> Individual <input type="checkbox"/> Corporation/Organization <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ <input type="checkbox"/> My Estate							
<input type="checkbox"/> Individual <input type="checkbox"/> Corporation/Organization <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ <input type="checkbox"/> My Estate							
<input type="checkbox"/> Individual <input type="checkbox"/> Corporation/Organization <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ <input type="checkbox"/> My Estate							
Total must equal 100%							%

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

##### 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
<input type="checkbox"/> Individual <input type="checkbox"/> Corporation/Organization <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ <input type="checkbox"/> My Estate							
<input type="checkbox"/> Individual <input type="checkbox"/> Corporation/Organization <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ <input type="checkbox"/> My Estate							
<input type="checkbox"/> Individual <input type="checkbox"/> Corporation/Organization <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ <input type="checkbox"/> 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 \_\_\_\_\_ dated \_\_\_\_\_ as amended and executed by me and said Trustee.  
Title of Agreement Date of Agreement

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



## Enrolling in Health Insurance Benefits at Retirement

Office of Human Resources, Montgomery County Government

# 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.**



**Enrolling in Health Insurance Benefits at Retirement**

Office of Human Resources, Montgomery County Government

# 2025 Retiree Monthly Rate Sheet 30% Cost Share

## RETIREE GROUP INSURANCE MONTHLY RATES 30.00% Cost Share Effective January 1, 2025

HEALTH PLANS	Non-Medicare			Medicare Only			Non-Medicare & Medicare Split <sup>1</sup>	
	Self 30.00%	Self + 1 30.00%	Family 30.00%	Self 30.00%	Self + 1 30.00%	Family 30.00%	Self + 1 30.00%	Family 30.00%
<b>MEDICAL:</b>								
CareFirst High Option POS (medical only)	\$ 252.93	\$ 437.54	\$ 736.72	\$ 136.29	\$ 252.59	\$ 280.86	\$ 320.90	\$ 620.08
CareFirst Standard Option POS (medical only)	\$ 235.22	\$ 406.90	\$ 685.16	\$ 126.75	\$ 234.92	\$ 261.20	\$ 298.43	\$ 576.68
UnitedHealthcare Select HMO (medical only)	\$ 207.05	\$ 398.02	\$ 632.74	\$ 111.56	\$ 227.52	\$ 361.06	\$ 302.54	\$ 537.26
Kaiser HMO (medical with Rx)	\$ 244.81	\$ 460.24	\$ 724.63	\$ 103.80	\$ 207.59	\$ 311.39	\$ 319.23	\$ 583.62
CareFirst Indemnity (medical with Rx discount)	\$ 387.56	\$ 625.47	\$ 1,238.27	\$ 200.11	\$ 416.60	\$ 616.53	\$ 638.01	\$ 1,050.81
<b>PRESCRIPTION:</b>								
Caremark Standard Option \$10/\$20/\$35	\$ 92.68	\$ 171.45	\$ 265.69	N/A	N/A	N/A	\$ 190.55	\$ 284.78
SilverScript Standard Option \$10/\$20/\$35	N/A	N/A	N/A	\$ 111.77	\$ 223.55	\$ 335.32	\$ 190.55	\$ 284.78
<b>DENTAL:</b>								
Dental PPO (Traditional Dental Plan)	\$ 13.15	\$ 29.30	\$ 42.17	\$ 13.15	\$ 29.30	\$ 42.17	\$ 29.30	\$ 42.17
<b>VISION:</b>								
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**		Optional Life Insurance per \$1,000 coverage 100% Monthly Rates	
Dependent Life Insurance	Age	Age	100% Monthly Rates
\$2,000/\$1,000	\$0.283	<25	\$0.049
\$4,000/\$2,000	\$1.751	25-29	\$0.056
\$10,000/\$5,000	\$4.377	30-34	\$0.069
		35-39	\$0.078
		40-44	\$0.084
<b>Basic Term Life Insurance</b>		45-49	\$0.118
		50-54	\$0.172
per \$1,000 coverage	\$0.089	55-59	\$0.310
		60-64	\$0.468
		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<sup>3</sup> \$ \_\_\_\_\_  
Dep Life<sup>3</sup> \$ \_\_\_\_\_  
Opt Life<sup>3</sup> \$ \_\_\_\_\_  
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 66 only for individuals who retired on or after January 1, 2016.



**Enrolling in Health Insurance Benefits at Retirement**  
Office of Human Resources, Montgomery County Government



# EyeMed Vision Comparison Chart

 <b>Retiree Vision Comparison</b> <i>(Effective: January 1, 2025)</i>		
	Current Discount Vision Plan	NEW Fully Insured Vision Plan
<b>Exam Services</b>		
Exam	\$5 Off	\$30 Copay
Contact Lens Fit and Follow Up	\$10 Off retail price	Maximum cost of \$40 for standard F&F and 10% off premium F&F
<b>Frames</b>		
	35% off retail price	\$130 frame allowance. \$0 copay and 20% off any amount over allowance.
<b>Standard Plastic Lenses</b>		
Single Vision	\$50	\$0 Copay
Bifocal	\$70	\$0 Copay
Trifocal	\$105	\$0 Copay
Progressive Lenses	\$65 for Standard. 20% off Tiers 1-4.	\$65-\$110 Copay for Standard. \$85-\$110 for Tiers 3 progressive. \$65 copay, 20% off retail price less \$120 allowance for Tier 4.
<b>Lens Options</b>		
UV Treatment	\$15	\$15
Tint-Solid or Gradient	\$15	\$15
Scratch Coating - Standard Plastic	\$15	\$15
Polycarbonate - Standard	\$40	\$40
Anti-Reflective Coating Standard	\$45	\$45
Other Add-Ons and Services	20% off retail price	20% off retail price
<b>Contact Lenses (Discounts applied to materials only)</b>		
Contacts-Disposable	0% off retail price	\$100 allowance
Contacts - Conventional	15% off retail price	\$100 allowance, 15% off amount above allowance
<b>Laser Vision Correction</b>		
Lasik or PRK	15% off retail price or 5% off promotional price	15% off retail price or 5% off promotional price
<b>Frequency</b>		
Examination, Frame, Lenses, Contact Lenses	Unlimited	Every calendar year for Exam and lenses. Every other calendar year for frame
<b>Monthly Premium**</b>		
Self Only	No charge	\$2.74
Self + 1		\$5.21
Self + Family		\$8.07

\*\*The new fully insured plan rates assume 100% cost-share. Your rates will reflect your personal retiree cost-share. To see your specific cost-share rates, please review the 2025 rate book available at [www.montgomerycountymd.gov/RetireeInsuredVision](http://www.montgomerycountymd.gov/RetireeInsuredVision).



**Enrolling in Health Insurance Benefits at Retirement**  
 Office of Human Resources, Montgomery County Government

# EyeMed Discount Vision ID Card



See more, get  
more, save more

EyeMed gives you choices—and lots of them. And with access to a vast network of independent eye doctors and popular retailers, it's easy to book an exam and use your discount. Plus, your Insight Discount Plan lets you score the hottest brands for less.



#### Locate an eye doctor

Our network has thousands of independent eye doctors and popular retailers. So you can see who you want to see when and where you want to see them. Visit [eyemed.com](http://eyemed.com) to find a provider near you.



#### Schedule an appointment

Schedule an appointment straight from [eyemed.com](http://eyemed.com), call ahead or stop by one of the many eye doctors that offer walk-ins. Most offer evening and weekend hours to fit any schedule.



#### Use your discount

When you arrive, let the eye doctor know you have an EyeMed discount through Montgomery County Government Retirees. Lucky you!

#### Insight Discount Plan 2019



Dependents are eligible.  
*This is not insurance.*

**Member Services**  
1-866-801-1479

**Montgomery County  
Government Retirees**  
Discount Plan#:  
1018309

Signature: \_\_\_\_\_

#### EyeMed Member Services

Visit [eyemed.com](http://eyemed.com) or call 1-866-801-1479

#### EyeMed Doctors/Providers Only

Visit [eyemed.com](http://eyemed.com) to receive plan information, authorization online or call 1-800-521-3605



## Enrolling in Health Insurance Benefits at Retirement

Office of Human Resources, Montgomery County Government

# Benefit Questions? Carrier Contact Information

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



Important Benefits Contact Information		
Resource	Phone	Web / Email
<b>Medical</b>		
• CareFirst BlueCross BlueShield	1-888-417-8385	<a href="http://www.carefirst.com">www.carefirst.com</a> 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	<a href="https://myhealth.kaiserpermanente.org/montgomerycountygovernment/">https://myhealth.kaiserpermanente.org/montgomerycountygovernment/</a>
◦ Baltimore area	1-800-777-7902	
• UnitedHealthcare HMO	1-800-638-0014	<a href="http://welcometouhc.com/mcg">http://welcometouhc.com/mcg</a> or <a href="http://www.myuhc.com">www.myuhc.com</a> Tip: This plan utilizes the Select EPO network
<b>Prescription</b>		
• Caremark	1-866-240-4926	<a href="http://www.caremark.com">www.caremark.com</a>
• SilverScript (Medicare-eligible retirees)	1-866-249-6167	<a href="http://www.mcg.silverscript.com">www.mcg.silverscript.com</a>
<b>Dental</b>		
• CIGNA	1-800-244-6224	<a href="http://www.cigna.com">www.cigna.com</a>
<b>Vision</b>		
• EyeMed	1-866-800-5457	<a href="http://www.eyemed.com">www.eyemed.com</a> Network: Insight
<b>Life, AD&amp;D, Optional Life and LTD1</b>		
• MetLife	1-800-638-6420	<a href="https://www.metlife.com/montgomery-county-government/">https://www.metlife.com/montgomery-county-government/</a>
<b>Flexible Spending Accounts</b>		
• Voya	1-888-401-3539	<a href="http://www.voya.com">www.voya.com</a> / <a href="https://myhealthaccount.voya.com">https://myhealthaccount.voya.com</a> Member Login
<b>Direct Bill and COBRA</b>		
• Voya	1-888-401-3539	<a href="http://www.voya.com">www.voya.com</a> / <a href="https://myhealthaccount.voya.com">https://myhealthaccount.voya.com</a> Member Login
<b>General Information</b>		
• MC311 OHR Customer Service Center	240-777-0311	<a href="http://www.mc311.com">www.mc311.com</a> 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	<a href="http://www.medicare.gov">www.medicare.gov</a>
• 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	<a href="http://www.ssa.gov">www.ssa.gov</a>

Revised 9/20/2024



## Enrolling in Health Insurance Benefits at Retirement

Office of Human Resources, Montgomery County Government

# 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



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.



**Enrolling in Health Insurance Benefits at Retirement**

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# 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](http://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 (1<sup>st</sup> 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.



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# 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 2025 Retiree Election Form \(montgomerycountymd.gov\)](https://montgomerycountymd.gov/RetireeElectionForm)
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.**



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# 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.



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# 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](http://www.montgomerycountymd.gov/hr)
2. Retiree Change of Address Form [www.montgomerycountymd.gov/MCERP](http://www.montgomerycountymd.gov/MCERP)



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# 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.



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# Returning Your Completed Forms

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

1. 2025 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. Kaiser Medicare Advantage Enrollment Form – [Medicare Eligible Kaiser Members](#)
5. Beneficiary Form
6. MD State 2025 Retiree Enrollment Form - [MD State Retirees Only](#)
7. MD State Beneficiary Form – [MD State Retirees Only](#)

You may mail, email, or hand deliver the required forms to OHR, by the deadline. Only send **copies** of birth certificates, U.S. Passports, and marriage certificates.



**Enrolling in Health Insurance Benefits at Retirement**

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# Returning Your Completed Forms (cont.)

Return the following form(s) to OHR once enrolled in Medicare Part B.

1. Kaiser Medicare Advantage Enrollment Form – If Age 65 or Medicare Eligible (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 1<sup>st</sup> day of your Retirement for full coverage.**



**Enrolling in Health Insurance Benefits at Retirement**

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# Returning Your Completed Forms (cont.)

## Return All Leave Payout Forms to the Payroll Department:

8<sup>th</sup> Floor EOB

101 Monroe Street, Rockville, MD 20850

[financepayroll@montgomerycountymd.gov](mailto: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.**



**Enrolling in Health Insurance Benefits at Retirement**

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**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](mailto: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 <https://mcuedcp.empower-retirement.com>.  
Your contribution increase will begin as soon  
as administratively feasible following  
Empower's receipt of this postcard.

Change my current contribution to:

☐ \$25 ☐ \$50 ☐ \$75 ☐ Other \$ \_\_\_\_\_ ☐ Other % \_\_\_\_\_☐ Pre-tax ☐ Roth

First and Last Name: \_\_\_\_\_

Last 4 of SSN or Empl# \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Signature: \_\_\_\_\_

Termination/Retirement Date: \_\_\_\_\_

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**Annual/Comp LEAVE PAYOUT FORM to:**[bryant.mayes@empower.com](mailto:bryant.mayes@empower.com)[payroll@montgomerycountymd.gov](mailto:payroll@montgomerycountymd.gov)**Do not return Leave Payout Forms to OHR.****Enrolling in Health Insurance Benefits at Retirement**

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# 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 1<sup>st</sup> 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.



**Enrolling in Health Insurance Benefits at Retirement**

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# 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.



**Enrolling in Health Insurance Benefits at Retirement**

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