

Member Services
900 7th Street, NW
2nd Floor
Washington, DC 20001
www.dcrb.dc.gov



Telephone (202) 343-DCRB
(866) 456-DCRB
TTY/Federal Relay (800) 877-8339
Facsimile (202) 566-5001
E-mail: dcrb.benefits@dc.gov

November 8, 2014

Dear Annuitant:

The 2015 Federal Employees' Health Benefits (FEHB) Open Season will begin on Monday, November 10, 2014 and end on Monday, December 8, 2014. During the Open Season you may:

- change from one health insurance plan to another;
- change your current health option to a different level, (e.g., switch from standard option to high option);
- change your enrollment type (e.g., from Self-Only to Self and Family);
- re-enroll in an FEHB plan if you suspended your FEHB plan to enroll in a Medicare Advantage plan or Tricare military health insurance program; or
- cancel your Federal Employees' Health Benefits plan. (**Please note:** if you cancel your health plan, you **will not** be permitted to re-enroll at a later date.)

Under FEHB, you can choose from among over 200 providers. To make it easier for you to compare plan provisions, the Office of Personnel Management (OPM) has developed a link which allows you to compare plans and access the plan brochures and other resource materials at OPM's recently updated insurance website:

<http://www.opm.gov/healthcare-insurance/healthcare/plan-information>.

The Guide to Federal Benefits booklet, which is also available on the OPM website <http://www.opm.gov/healthcare-insurance/healthcare/plan-information/guide/2015-guides/70-9.pdf> contains more than just health benefit plan information. The guide also provides information on the Federal Employees' Dental and Vision Insurance Program (FEDVIP) (see information below), Federal Employees' Group Life Insurance (FEGLI) Program, and the Federal Long Term Care Insurance Program (FLTCIP). The FEGLI and FLTCIP programs are not a part of the annual Open Season.

Health Coverage

1. **If you are satisfied with your current health insurance coverage, you do not have to do anything.** Your current health insurance coverage will continue automatically.
2. **If you wish to make a change to your health coverage, please complete the enclosed *Health Benefits Election Form (SF-2809)*.** This form is also available on the District of Columbia Retirement Board (DCRB) website at www.dcrb.dc.gov (follow the *Retirement – Member Forms – Health and Life Insurance Forms – Federal Health Benefits Election Form* pathway) and on the OPM website at http://www.opm.gov/forms/pdf_fill/sf2809.pdf. Additionally, you may call DCRB Member Services Center at (202) 343-3272 or toll-free at (866) 456-3272 to obtain forms.

Please note that completed enrollment forms will be accepted by the DCRB's Member Services Center at the above address up to close of business on Friday, December 12, 2014.

FEDVIP Program

The FEDVIP Program is a dental and vision care benefit program administered by BENEFEDS, a vendor selected by OPM. The FEDVIP program is available to Federal retirees and survivors of retirees (including District employees who were first hired by the District government prior to October 1, 1987).

The FEDVIP program is flexible. You can enroll in self-only coverage, self-plus-one dependent, or self-plus-family. You do not have to be enrolled in the FEHB program to be eligible to enroll in the dental and vision care plans. However, you must have elected an immediate annuity upon retirement to participate in these plans. You may:

1. enroll both a dental plan and a vision plan;
2. enroll in a dental only or vision plan only; or
3. choose not to enroll at this time.

Retirees who elected to receive a deferred annuity **are not** eligible for this program.

Premiums for the FEDVIP program **will not** be deducted from your monthly annuity payment. OPM and BENEFEDS have established an automatic bank withdrawal process that allows premiums to be deducted from your personal checking account on a monthly basis. Information on the dental and vision providers is contained in the open enrollment brochure.

If you have access to the internet, you can obtain information on these programs by accessing www.BENEFEDS.com. The website will provide additional details about the plans as well as the premiums for each. In addition, you may use the website to enroll in the FEDVIP program. If you do not have access to the internet, you may contact the FEDVIP customer service line at (877) 888-3337 to obtain more information. All calls pertaining to this program should be directed to this special toll-free number. The FEDVIP customer service representatives will also be able to take your enrollment information over the phone.

When will Open Season changes become effective?

If you are making a change to your health insurance plan, the change will become effective on January 1, 2015. The rate change, if any, will be reflected in your February 1, 2015 annuity payment.

If you would like more information on the health insurance plans, please contact DCRB's Member Services Center at (202) 343-3272. If you are outside of the Washington, DC Metro Area, you may call the DCRB toll-free number at (866) 456-3272. If you would like to learn more about the FEDVIP program, please contact BENEFEDS at (877) 888-3337.

Sincerely,

Member Services Center
DCRB Benefits Department

Enclosures

ATTENTION:

If you have **NO** changes to your health coverage,
DO NOT complete the enclosed form!



Health Benefits Election Form

Part A - Enrollee and Family Member Information (For additional family members use a separate sheet and attach.)

1. Enrollee name (last, first, middle initial)	2. Social Security number	3. Date of birth (mm/dd/yyyy)	4. Sex <input type="checkbox"/> M <input type="checkbox"/> F	5. Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Home mailing address (including ZIP Code)		7. If you are covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D	8. Medicare Claim Number	
9. Are you covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 10 below. <input type="checkbox"/> No				

10. Indicate the type(s) of other insurance:
 TRICARE Other: Name of other insurance: _____ Policy number: _____
 FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.

11. Name of family member (last, first, middle initial)	12. Social Security number	13. Date of birth (mm/dd/yyyy)	14. Sex <input type="checkbox"/> M <input type="checkbox"/> F	15. Relationship code
16. Address (if different from enrollee)		17. If this family member is covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D	18. Medicare Claim Number	
19. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 20 below. <input type="checkbox"/> No				

20. Indicate the type(s) of other insurance:
 TRICARE Other: Name of other insurance: _____ Policy number: _____
 FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.

21. Email address (if home address is different from enrollee's)	22. Preferred telephone number (if home address is different from enrollee's)			
23. Name of family member (last, first, middle initial)	24. Social Security number	25. Date of birth (mm/dd/yyyy)	26. Sex <input type="checkbox"/> M <input type="checkbox"/> F	27. Relationship code
28. Address (if different from enrollee)		29. If this family member is covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D	30. Medicare Claim Number	
31. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 32 below. <input type="checkbox"/> No				

32. Indicate the type(s) of other insurance:
 TRICARE Other: Name of other insurance: _____ Policy number: _____
 FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.

33. Email address (if home address is different from enrollee's)	34. Preferred telephone number (if home address is different from enrollee's)			
35. Name of family member (last, first, middle initial)	36. Social Security number	37. Date of birth (mm/dd/yyyy)	38. Sex <input type="checkbox"/> M <input type="checkbox"/> F	39. Relationship code
40. Address (if different from enrollee)		41. If this family member is covered by Medicare, check all that apply. <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D	42. Medicare Claim Number	
43. Is this family member covered by insurance other than Medicare? <input type="checkbox"/> Yes, indicate in item 44 below. <input type="checkbox"/> No				

44. Indicate the type(s) of other insurance:
 TRICARE Other: Name of other insurance: _____ Policy number: _____
 FEHB An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.

45. Email address (if home address is different from enrollee's)	46. Preferred telephone number (if home address is different from enrollee's)			
--	---	--	--	--

Part B - FEHB Plan You Are Currently Enrolled In (if applicable)

1. Plan name	2. Enrollment code
--------------	--------------------

Part C - FEHB Plan You Are Enrolling In or Changing To

1. Plan name	2. Enrollment code
--------------	--------------------

Part D - Event That Permits You To Enroll, Change, or Cancel (see page 2)

1. Event code	2. Date of event ___ / ___ / ___
---------------	-------------------------------------

Part E - Election NOT to Enroll (Employees Only)

I do NOT want to enroll in the FEHB Program.
My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.

Part F - Cancellation of FEHB

I CANCEL my enrollment.
My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.

Part G - Suspension of FEHB (Annuitants/Former Spouses Only)

I SUSPEND my enrollment.
My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.

Part H - Signature
WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than \$10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature (do not print)	2. Date (mm/dd/yyyy) ___ / ___ / ___
3. Email address	4. Preferred telephone number ()

Part I - To be completed by agency or retirement system
REMARKS

1. Date received (mm/dd/yyyy)	2. Effective date of action (mm/dd/yyyy)	3. Personnel telephone number ()
4. Name and address of agency or retirement system _____		5. Authorizing official (please print)
		6. Signature of authorized agency official
7. Payroll office number	8. Payroll office contact (please print)	9. Payroll telephone number ()



IMPORTANT

Medicare Information for Annuitants Only

AT AGE 65, MEDICARE BECOMES THE PRIMARY PAYER OF YOUR RETIREE HEALTHCARE EXPENSES AND YOUR RETIREE HEALTH INSURANCE BECOMES THE SECONDARY PAYER. IF YOU ARE NOT ENROLLED IN MEDICARE AT AGE 65, YOU WILL INCUR OUT-OF-POCKET HEALTH CARE EXPENSES.

You are eligible for Medicare beginning at age 65. If you are already receiving Social Security benefits, you automatically receive Part A (Hospital Insurance) and Part B (Medical Insurance) beginning the first day of the month you turn 65. If your birthday is on the first day of the month, Part A and Part B will start the first day of the prior month.

If you are automatically covered by Part A, you do not have to pay premiums. However, if you do not automatically qualify for Part A, and you are age 65 or older, you may buy Part A.

Part B requires monthly premiums, whether you are automatically covered or choose to buy coverage.

If you are close to age 65, but are not receiving Social Security benefits and you would like Part A and/or Part B, you *must* enroll by contacting Social Security 3 months before your turn age 65. You can also apply for Part A and Part B at www.socialsecurity.gov/retirement.

If you do not sign up for Part B when you are first eligible, you may have to pay a late enrollment penalty for as long as you have Part B.

Please call Social Security at 1-800-772-1213 for more information about your Medicare eligibility and to sign up for Part A and/or Part B. You may also visit www.medicare.gov for general information about enrolling. To receive personalized health insurance counseling at no cost to you, contact your State Health Insurance Assistance Program (SHIP).

If you are not automatically enrolled in Medicare, and you would like Part A and/or Part B, you can sign up during these times:

Initial Enrollment Period: You can sign up for Part A and/or Part B during the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

If you sign up for Part A and/or Part B during the first 3 months of your Initial Enrollment Period, in most cases, your coverage starts the first day of your birthday month. However, if your birthday is on the first day of the month, your coverage will start the first day of the prior month.

(over)

Enroll in Medicare Part B during your Initial Enrollment Period!

When can I first sign up for Medicare?

You may sign up for Medicare during the Initial Enrollment Period which is a 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

What is the General Enrollment period and when is it?

If you miss your enrollment opportunity during your Initial Enrollment Period, you may enroll during the General Enrollment Period. This period is between January 1—March 31 of each year. If you enroll during this time, your coverage will start July 1st.

Medicare Information for Annuitants Only

(continued)

If you enroll in Part A and/or Part B the month you turn 65 or during the last 3 months of your Initial Enrollment Period, the start date for your Medicare coverage will be delayed.

General Enrollment Period: If you did not sign up for Part A and/or Part B when you were first eligible, you can sign up between January 1 – March 31 of each year. Your coverage will begin July 1 of that year. You may have to pay higher Part A and/or Part B premium for late enrollment.

In many cases, if you choose to buy Part A, you must also have Part B and pay monthly premiums for both.

To learn more about enrollment periods, visit www.medicare.gov/publications to view the booklet “Enrolling in Medicare Part A & Part B.” You may also call 1-800-MEDICARE (1-800-633-4227) for more information.

You are not required to enroll in Medicare if you are not automatically covered, but your lack of coverage will result in out-of-pocket healthcare expenses you will be responsible for paying to your healthcare provider.

Your health insurance premiums are not reduced if you enroll in Medicare, but you may decide to change to a lower cost health plan. Please contact your health insurance provider with any questions.

Helpful Resources

Medicare
1-800-MEDICARE (633-4227)

Medicare Publications
[www.medicare.gov/
publications](http://www.medicare.gov/publications)

Medicare
General Information
www.medicare.gov

Social Security
Administration
1-800-772-1213
[www.socialsecurity.gov/
retirement](http://www.socialsecurity.gov/retirement)

