If you don't want Medicare Advantage coverage

How to opt out of Medicare Plus Blue℠ Group PPO coverage

Effective January 1, 2020, the State Health Plan PPO converted from a Medicare supplemental plan to a Medicare Advantage (MA) plan. You will be automatically enrolled in the Medicare Plus Blue Group PPO plan (State Health Plan MA) unless you notify the Office of Retirement Services (ORS) that you do not want this coverage.

How to opt out of Medicare Plus Blue Group PPO coverage

If you decide that you **do not** want coverage under the **State Health Plan MA** or would like to enroll in the Medicare Supplemental plan (State Health Plan PPO) because you carry other primary insurance coverage, then complete the form on the back of this page, sign where requested and send it to ORS using the address or fax number below.

Important:

- Only return this form if you **do not** want to be covered by the Medicare Advantage plan offered through the **State Health Plan MA**.
- If you wish to decline **State Health Plan MA** coverage and remain in the State Health Plan PPO, you must provide proof of other primary insurance coverage in another Group plan. Accepted proof of coverage may be either a photocopy of your insurance ID Card, a letter from the other carrier, or an open enrollment confirmation form confirming current coverage.
- If you are the State retiree, and you decide to opt out of the **State Health Plan MA** coverage, and aren't eligible to stay in the current State Health Plan PPO, everyone on your health care contract will also be opted out. **All members on your contract will no longer have coverage through the State.**
- Declining State Health Plan MA coverage may affect other coverage the State offers, such as prescription drugs. Before submitting this form, contact the ORS to find out what will happen to those benefits if you opt out of State Health Plan MA coverage and to discuss other health coverage options available through the State.

Return the enclosed form to:

Office of Retirement Services
P.O. Box 30171
Lansing, MI 48909-7671

To return by fax, dial 517-284-4416.

If you want **State Health Plan MA** coverage, do not return this form. However, if you receive a letter requesting additional information regarding your enrollment, please respond promptly so that we can complete the enrollment process. Once we receive your information, we will submit your enrollment request to the Centers for Medicare & Medicaid Services (CMS).

For questions about this form or the State Health Plan MA coverage, please call the ORS at one of the telephone numbers listed below:

Local Lansing area: (517) 284-4400
Toll Free: (800) 381-5111
Monday through Friday from 8:30 a.m. to 5 p.m., Eastern time.
TTY users should call 711.

OPT-OUT FORM **State Health Plan MA, Medicare Plus Blue Group PPO**

If you wish to decline coverage, complete all sections below and return to ORS. Please print.

Name	**Date of birth**
SSN	**Medicare ID no. (if applicable)**

Important: *You can only be enrolled in one Medicare Advantage plan at a time. If you are already enrolled in an individual Medicare Advantage plan or an individual Medicare Prescription Drug (Part D) plan, or if you are covered through your spouse's Medicare Advantage or Medicare Prescription Drug plan, you must decide which plan you wish to keep. If you do not use this form to notify us that you are enrolled in another plan, we will enroll you in the* **State Health Plan MA** *coverage and Medicare will automatically cancel your other Medicare Advantage health plan.*

❑ **I decline State Health Plan MA Medicare Advantage coverage and State Health Plan PPO Medicare Supplemental coverage, and I understand this will result in cancellation of all health and prescription drug benefits currently covered by the State. I also understand if I am the retiree, this will result in cancellation of all health and prescription drug benefits for all my dependents as well.**

❑ **I decline State Health Plan MA Medicare Advantage coverage and ACCEPT State Health Plan PPO Medicare Supplemental coverage for myself. I have included my proof of alternate primary insurance coverage.**

Once you or your representative have checked one box above and provided any requested information, please complete the information below, sign, and date.

X_____ _____

Signature **Date**

(____) _____

Daytime phone no.

If you are signing as the contract holder's authorized representative, please complete the section below.

The following is authorized to act on behalf of the individual above under the laws of the State in which the individual resides. If signed by an authorized individual, this signature certifies that: 1) this person is authorized under State law to complete this opt-out form and 2) documentation of this authority is available upon request.

Name of representative	**Daytime phone no.**
Address	**Relationship to retiree**

FOR OFFICE USE ONLY					
ORS Rec'd date:		Confirm date		ORS Rep name	
Please check one	❑ Opt-out confirmed ❑ Opt-out reversed (Member will be enrolled) ❑ Enroll contract holder/remove dependent ❑ Other _____				
Comments:					