If you don't want Medicare Advantage (MA) coverage, *complete this form to opt out of the State Health Plan MA PPO*

Due to your upcoming change in Medicare eligibility, you will automatically be transitioned from the State Health Plan PPO into the **State Health Plan MA PPO**, a Medicare Plus Blue[SM] Group PPO plan administered by Blue Cross Blue Shield of Michigan. If you don't want this coverage, you must notify the Office of Retirement Services (ORS).

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 PPO** plan or would like to enroll in the Medicare Supplemental plan (State Health Plan PPO) because you carry other primary insurance coverage, you must complete the form on the back of this page, sign where requested, and send it to the ORS using the address or fax number below.

Important:

- Only return this form if you **do not** want the Medicare Advantage plan offered through the **State Health Plan MA PPO**.
- If you wish to decline the **State Health Plan MA PPO** coverage and remain in the State Health Plan Medicare Supplemental PPO, you must provide proof of other primary insurance coverage in another group plan. Accepted proofs of coverage may be either a photocopy of your member ID card, a letter from the other carrier, or an open enrollment form confirming current coverage. Medicare-eligible dependents and spouses must be enrolled in the same plan as the retiree.
- If you are a State retiree and you decide to opt out of the **State Health Plan MA PPO** coverage and are not eligible to remain enrolled in the State Health Plan PPO, everyone on your health care contract will also be opted out and disenrolled. **All members on your contract will no longer have health care coverage through the State of Michigan.**
- Declining **State Health Plan MA PPO** 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 the **State Health Plan MA PPO** coverage and to discuss other health care coverage options available through the State of Michigan.

Return the enclosed form to:
Office of Retirement Services
P.O. Box 30171
Lansing, MI 48909-7671
To return this form by fax, dial 1-517-284-4416.

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

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

Local Lansing area: **1-517-284-4400**
Toll Free: **1-800-381-5111**
Monday through Friday from 8:30 a.m. to 5 p.m. Eastern time.

OPT-OUT FORM **State Health Plan Medicare Advantage (MA) PPO**

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

Name	**Date of birth**
SSN	**Medicare Beneficiary ID number (if applicable)**

Important: *You can only be enrolled in one Medicare Advantage (MA) plan at a time. If you are already enrolled in an individual MA plan or an individual Medicare Prescription Drug (Part D) plan, or if you are covered through your spouse's MA 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 PPO** *and Medicare will automatically cancel your other MA health plan.*

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

❑ **I decline State Health Plan MA PPO coverage and ACCEPT State Health Plan PPO Medicare Supplemental coverage for myself. I have included my proof of other 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 number

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**
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:					