RETIREE BENEFITS STATEMENT FORM

Retiree ID:

RETIREE NAME
RETIREE ADDRESS
ADDRESS
RETIREE CITY STATE ZIP

Health Care and Benefits Division
PO Box 200130
Helena, MT 59620-0130

INSTRUCTIONS & DEADLINE FOR ELECTIONS:
Review your elections carefully by verifying the types and amounts of coverage, reviewing benefit offerings available online at www.benefits.mt.gov, and making any necessary changes to the appropriate sections of this form by **November 18, 2015**. This form must be postmarked or returned to the Health Care and Benefits Division (HCBD) by **November 18, 2015**. The form may be sent through the U.S. Postal service, through the State of Montana (deadhead) mail service, or dropped off at 100 N Park, Suite 320 in Helena.

CURRENT BENEFIT	*2015 COVERAGE	2015 BENEFIT PAYMENT	2016 BENEFIT PAYMENT
Medical**			
Dental			
Vision Hardware (Re-enrollment required)			
Basic Life			
Live Life Well Discount***			
MEDICARE STATUS as of 10/2015 (Your coverage and your spouse's, if applicable, is Non-Medicare unless MDCR [Medicare] is indicated)			
TOTAL OUT-OF-POCKET CONTRIBUTION COSTS			

*As of October 16, 2015

If you completed Live Life Well incentive activities or sent in the Life Life Well incentive certification after October 16, 2015, your discount may not correctly be reflected on this statement. You have until October 31, 2015 to complete all incentive activites to qualify for the 2016 Live Life Well Discount. Take into consideration your incentive activities when calculating your out-of-pocket costs. For more information contact Health Care and Benefits at (800) 287-8266.

Add or delete dependents (s): Verify that the information below is accurate. Make changes where necessary. Please remember, retirees are required to participate in medical, dental, and basic life for non-Medicare retirees. During this annual change period, dependent children under 26 years of age and a spouse or domestic partner may be added. To delete/add a dependent from coverage, check the Delete/Add box next to each dependent's name and **circle** the type of coverage to be deleted/added.

Delete	Add	Coverage**	Name	Birthdate	Rel*	SSN
❑	❑					
❑	❑					
❑	❑					
❑	❑					
❑	❑					
❑	❑					

*Rel. = Relationship • E = Retiree • SP = Spouse • D = Daughter • S = Son • X = Disabled DP= Domestic Partner
**Coverage = • M = Medical • D=Dental • V=Vision

I. DENTAL - Basic dental will not be available in 2016. See your Annual Change book for more details.

❑ Premium ❑ Dental (Medicare-only) ❑ No Change

II. VISION HARDWARE COVERAGE - Choose the appropriate box below. You or your dependent must be enrolled in medical to be eligible for vision hardware. Please note if you choose to participate in the vision hardware plan, **all** dependents enrolled in the medical plan will be enrolled.

❑ Yes, I want to enroll ❑ No, I do NOT want to enroll

III. OPTIONS TO TERMINATE BENEFITS- You may find it beneficial to consider switching from the State of Montana Health Plan to a plan available on the individual marketplace (under 65) or a Medicare supplement Plan (over 65). Retirees choosing to leave the State of Montana Health Plan will have a one-time opportunity to return to the State of Montana retiree plan during an annual change enrollment period. Retirees must notify the Health Care and Benefits Division within two years of their benefit coverage termination date and they will be allowed to re-enroll in the next annual change period, typically held in the fall of each year. Your coverage will be effective January 1 of the next plan year.

❑ I would like to terminate my State of Montana Retiree Benefit Plan coverage to enroll in an individual marketplace product or a Medicare supplement plan.

IV. READ AND SIGN

NOTICE OF CHANGE IN PROCESS: You will no longer receive a confirmation statement. The elections that you make on this form are final and will be binding for the upcoming plan year unless you or your dependent have a qualifying event as described in the Summary Plan Document.

I request the changes indicated above. **I understand that there will not be a confirmation process this year, and that the changes indeicated above are final.**

Signature:_____Date:_____