2017 Retiree, Surviving Spouse and LTD Recipients
Benefits Handbook
Benefits & Wellness Department
Human Resources
www.wayne.edu/hr/tcw
If you have Medicare or will become eligible for Medicare in the next 12 months, a new Federal Law gives you more choices about your prescription drug coverage.

For more information and your Creditable Coverage Notice, please see pages 23-24.
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## RETIREE ADDRESS AND BENEFICIARY CHANGES

As an official retiree of the University you have retiree life insurance at no cost to you. It is important to update your address and beneficiary information, as life changes. Discuss this issue with your family and other retirees, so that we may keep connected to you. Please call Benefits & Wellness at (313) 577-3000 to update your address and/or beneficiary information. Thank you!

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WELCOME

The Wayne State benefit programs you receive as an eligible participant are administered by the Benefits & Wellness Department (B&W). We believe the information found in this handbook will be valuable to you. We urge you to keep this handbook and refer to it when you have questions about your benefits.

The WSU benefit programs include the following:
- Medical Insurance
- Life Insurance
- Dental Insurance
- Vision Insurance
- 403(b) Retirement Plans

If you have questions about these benefits, please call, write or visit us at:

**Phone Number:** (313) 577-3000
**Fax:** (313) 577-0637

**Address:**
5700 Cass Ave, Suite 3638
Detroit, MI 48202

**Location:** Corner of Cass and Palmer

**Web Address:** www.wayne.edu/hr/tcw (Benefits Handbook and Forms available online)

**Office Hours:** 8:30 a.m. to 5:00 p.m. Monday through Friday

**E-mail:** askhr@wayne.edu

### Directory

<table>
<thead>
<tr>
<th>Name</th>
<th>Area of Specialty</th>
<th>Phone</th>
<th>E-mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR Service Center</td>
<td>Benefits &amp; Wellness</td>
<td>(313) 577-3000</td>
<td><a href="mailto:askhr@wayne.edu">askhr@wayne.edu</a></td>
</tr>
<tr>
<td>Merilyn Merkison</td>
<td>Senior Benefits Program Manager</td>
<td>(313) 577-6347</td>
<td><a href="mailto:ad0874@wayne.edu">ad0874@wayne.edu</a></td>
</tr>
<tr>
<td>Hannah Fleet</td>
<td>403(b) Retirement Programs</td>
<td>(313) 577-7830</td>
<td><a href="mailto:fp6399@wayne.edu">fp6399@wayne.edu</a></td>
</tr>
<tr>
<td>Albert Bowman</td>
<td>Medical Claims Assistance, Retirement Consultation, Retiree Contact</td>
<td>(313) 577-6353</td>
<td><a href="mailto:ab3895@wayne.edu">ab3895@wayne.edu</a></td>
</tr>
<tr>
<td>Charlene Allemon</td>
<td>LTD Administration, Death Claim Processing</td>
<td>(313) 577-6351</td>
<td><a href="mailto:bq1193@wayne.edu">bq1193@wayne.edu</a></td>
</tr>
</tbody>
</table>

This booklet is intended as a convenient summary of the major points of benefit plans for retirees, surviving spouses, and eligible LTD recipients effective January 1, 2017 global effective date. This booklet does not cover all provisions, limitations and exclusions. Wayne State University reserves the right to amend, modify, or terminate these Plans at any time and in any manner.

**YOU SHOULD KEEP THIS BOOK THROUGHOUT THE YEAR FOR REFERENCE PURPOSES.**
• **Medical Insurance** through Wayne State University is available to all university retirees. If you do not currently have medical insurance through WSU, you may enroll during open enrollment in November/December with coverage effective January 1 or, during the year, according to the guidelines specified in the chart on pages 6 through 7. Currently, the retiree medical premiums vary depending on your insurer and type of coverage (single, two person or family). A comparison chart of the various plans is available on pages 14 through 19. Information regarding the appropriate enrollment form and where to send it appears on page 8. Retirees are billed for the monthly premium by the university’s billing agent.

• **Life Insurance** is provided at no cost to the retiree. The amount is determined by your date of retirement. Those who retired on or after July 1, 1968 have a $2,500 policy. Those who participated in an Early Retirement Incentive Program may have a $25,000 policy. If you would like to update your beneficiary, please complete the Sun Life Insurance Change of Beneficiary form on page 69. Please be sure to sign and date the form. Once completed, the form must be returned to the Department of Benefits & Wellness, 5700 Cass Avenue, Suite 3638, Detroit, MI 48202.

• **Dental Insurance** is available through Delta Dental at the time of retirement or during open enrollment each year. Please see pages 59 through 63 for information, rates and the enrollment form. Once completed, the enrollment form must be returned to the Department of Benefits & Wellness. Please note coverage must remain in force for at least 12 months. Retirees are billed for the monthly premium by the university’s billing agent.

• **Vision Insurance** is available through EyeMed at the same level of coverage offered to active employees. Please see pages 65 through 68 for information, rates and the enrollment form. Please note coverage must remain in force for at least 12 months. Retirees are billed for the monthly premium by the university’s billing agent.

• **Retiree Identification Card** provides continued access to the university library system, the Matthaei facilities, and any discounts that may be available for the university theatres and bookstore. The retiree One Card also allows you to join the Recreation and Fitness Center ($252 annually) or use the facilities on a daily basis ($10 per visit). If you do not already have a retiree identification card, please apply by contacting the One Card Service Center at 313-577-8663.

• **A WSU E-mail account** (on the Wayne Connect Communication and Collaboration System on the Web) and other computing and network services are available to all university retirees, using a WSU AccessID and password. (For more information, see page 71-72). If you have questions about using your WSU E-mail account or other AccessID services, please contact the Computing & Information Technology Help Desk at 313-577-4778 or visit C&IT’s website at www.computing.wayne.edu/email.

• **University Parking** - as a retiree, you are eligible for free university parking. Please contact Parking and Transportation Services at 313-577-3704 for information.

• **Educational Opportunities** – Thinking about returning to school? Students who are age 60 or older are eligible for a 75% reduction in the regular tuition rate. Contact Registration and Scheduling at 313-577-8193 for details. Or you may wish to enroll in SOAR (Society of Active Retirees) for a nominal fee. Classes are offered through the WSU Oakland Center in Farmington Hills. For more information, please call 248-489-0005.

• **Retirement Funds** – For information regarding the various options available to you through TIAA-CREF and/or Fidelity Investments, please contact the companies directly. Please remember it is also important to advise them of any change of address. TIAA can be reached at 1-800-842-2776. Fidelity Investments can be reached at 1-800-642-7131.
The following list of telephone numbers for retiree benefits may be helpful:

**Investments**
- Turning savings into income
- Timing Social Security
- Planning for health costs
- Leaving a legacy

**TIAA/CREF Investments**
Illustrations of Income/Consulting/Forms ....................... 1-800-732-8353
TIAA website: www.tiaa-cref.org

**Fidelity Investments**
Individual Consulting/Forms .................................. 800-343-0860 (Fidelity Retirement Services)
Fidelity website: www.fidelity.com

**Social Security Retirement** ........................................ 1-800-772-1213
Social Security Administration website: www.ssa.gov

**Medical insurance** .................................................. 313-577-3000 (WSU Benefits & Wellness)
Applying for Medicare (if age 65 or older) ...................... 1-800-772-1213 (Social Security Administration)
Medicare website: www.medicare.gov
Medicare Assistance: 1-800-803-7174
Medicare Coordination of Benefits: 1-800-999-1118

**Life insurance**
Change of beneficiary (page 69) ................................. 313-577-3000 (WSU Benefits & Wellness)

**Delta Dental insurance** ............................................. 1-800-524-0149 (Delta Customer Service)

**EyeMed Vision insurance** ......................................... 1-866-939-3633 (EyeMed Customer Service)

**Retiree identification card** ....................................... 313-577-8663 (WSU One Card Office)

**University parking** .................................................. 313-577-3704 (WSU Parking Authority)

**Using e-mail from home** ........................................... 313-577-4778 (WSU Computing & Information Tech Help Desk)

**Continuing Education** ............................................. 313-577-8193 (WSU Registration and Scheduling)
248-489-0005 (SOAR – Society of Active Retirees)

**Benefit Services for new or prospective retirees** .......... 313-577-3000 (WSU Benefits & Wellness),
email: askhr@wayne.edu

**Benefit Services for Retirees**
- Address changes
- Changes to life insurance beneficiaries
- Add/terminate dependents
- Terminating medical/dental/vision coverage
Retiree and Surviving Spouse and LTD Recipient
In general, you qualify for medical, dental and vision insurance provided by the University if you are a retiree or an eligible former employee receiving long-term disability insurance benefits through the university’s disability insurance carrier. Surviving spouses of retirees are eligible only for medical insurance. These qualifying individuals are known as subscribers.

Dependents
You can enroll your dependents in the medical benefits. Eligible dependents include your:

• Legal spouse.
• Other Eligible Person (OEP) – A retiree or LTD recipient who does not already cover a spouse for health or dental benefits may enroll one eligible person if he or she meets the following criteria:
  • The OEP is an adult, age 26 or older;
  • The OEP currently resides in the same residence as the employee and has done so for the 18 continuous months prior to the individual’s enrollment other than as a tenant;
  • The OEP is not a “dependent” of the employee as defined by the IRS; and
  • The OEP is not related by blood or marriage.

• Your children or the children of your spouse:
  • Children by birth or adoption until the end of the calendar month in which they reach the age of 26.
  • Children by legal guardianship
• Principally supported children (not your children by birth or marriage) through the end of the year in which they reach age 19 who are:
  • principally supported by you for at least six consecutive months, (nine months for BCBS),
  • related to you by blood or marriage, and
  • claimed as your dependents on your most recent income tax return.

• Unmarried disabled dependent children who:
  • have reached the end of the month in which they turned 26,
  • are dependent on you for support and maintenance,
  • became disabled before reaching age 19, and
  • are incapable of self-sustaining employment by reason of mental or physical handicap.

• Your sponsored dependent, defined as:
  • an adult, age 26 or older
  • dependent on your financial support,
  • claimed on your most recent tax-return, and
  • who resides with you permanently.

• Your senior rider, defined as:
  • an adult, age 65 or older,
  • dependent on your financial support,
  • claimed on your most recent tax-return,
  • who resides with you permanently, and
  • is enrolled in Medicare Part A and B.

The University may request proof that any claimed dependents are legal and eligible for coverage on the medical, dental and vision plans. Any ineligible dependents will be removed from your coverage.
PAYING FOR YOUR BENEFITS

You will receive a monthly invoice from Automated Benefit Services (the billing administrator for Wayne State University). Invoices are mailed out so they are received two weeks prior to the month of coverage. Please note that all invoices are due on the first of the month following receipt. For example, the invoice for medical insurance for the month of March should be received on or about February 15th and is due on March 1st.

When you do receive your invoice, please review it for accuracy. We are limited in the amount of time we can correct errors. Our insurance carriers allow for corrections no more than 60 days retroactively. If you have any questions on the invoices, please call Automated Benefit Services (ABS) at (800) 645-9978. If you are an Aetna MedicareSM (PPO) subscriber, please call Aetna toll-free at (888) 267-2637 with any invoicing or rate questions.

Please be aware, after 60 days, non-payment of an invoice will result in termination of your coverage. You will be responsible for all invoices issued prior to your termination date.

YOUR RESPONSIBILITIES

To change your coverage during open enrollment, forms must be returned to the Benefits & Wellness Department no later than the communicated deadline. If you are enrolling in Aetna MedicareSM (PPO) as a retiree or surviving spouse, enrollment forms must be sent directly to Aetna. If you are enrolling in Aetna MedicareSM (PPO) as an LTD recipient, enrollment forms must be sent to Benefits and Wellness.

You must notify the Benefits & Wellness Department of any change in your family status. (ie., you have only 30 days from the date of marriage to add a new spouse.) Providing information about other coverage your family members may be entitled to is your responsibility and helps ensure your costs are kept as low as possible. If you fail to provide such information when asked by the Insurance Company or Wayne State University, claim payments will be suspended until the information is provided.

RATES

Please note rate schedule included with this book or see our web site www.wayne.edu/hr/tcw. Rates for dental and vision are included on the enrollment forms. If you have a question about rates, please call the Benefits & Wellness Department at (313) 577-3000.

Ineligibility

Please review the eligibility requirements described above. Determine if your current dependents are still eligible for coverage based upon the eligibility guidelines. Any ineligible dependents should be removed from your coverage as soon as they become ineligible. As a reminder we have included a few examples of ineligible dependents:

• Anyone who is not your legal spouse or qualified Other Eligible Person as defined on page 4.
• Dependents no longer covered by a court order.

Ineligibility (continued)

ELIGIBILITY (continued)
Please note that because of the contracts Wayne State University has with the medical insurance carriers, the Benefits & Wellness Department must strictly administer these time limits.

<table>
<thead>
<tr>
<th>Event</th>
<th>Time Limit</th>
<th>When &amp; How Effective</th>
<th>Documents Required</th>
<th>Consequences of Missing Time Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquiring a new dependent</td>
<td>30 days from date of marriage or having met</td>
<td>Date of marriage or other eligible person qualifying if forms are received by the</td>
<td>Medical Plan Enrollment form.</td>
<td>If coverage is with BCBS or HAP, dependent may be added the first of the month following a 90-day</td>
</tr>
<tr>
<td>• marriage</td>
<td>the other eligible person requirements on page 4.</td>
<td>the Benefits &amp; Wellness Department within 30 days of the event. Cannot change carriers at this point.</td>
<td></td>
<td>waiting period which begins the date enrollment forms are received by the Benefits &amp; Wellness</td>
</tr>
<tr>
<td>• newborn</td>
<td></td>
<td></td>
<td></td>
<td>Department. If coverage is with other carriers dependent may be added during the next open</td>
</tr>
<tr>
<td>• adoption</td>
<td></td>
<td></td>
<td></td>
<td>enrollment.</td>
</tr>
<tr>
<td>• OEP relationship</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Acquiring new sponsored dependent or senior</td>
<td>Only during open enrollment, or if coverage is</td>
<td>January 1 if changing during open enrollment, or 1st of the month following 90-day</td>
<td>Medical Plan Enrollment form. Sponsored Dependent/ Senior Rider application. Most recent tax return showing dependent as dependent.</td>
<td>Only HAP is available. Coverage effective the first of the month following a 90-day waiting period which begins the date the enrollment forms are received by the Benefits &amp; Wellness Department. Other carriers are not available until the next open enrollment.</td>
</tr>
<tr>
<td>senior rider</td>
<td>HAP any time during the year and open enrollment.</td>
<td>waiting period if coverage is HAP. Request for additions during open enrollment must be received by the Benefits &amp; Wellness Department by the communicated deadline.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancel coverage</td>
<td>Anytime</td>
<td>End of the month following receipt of notification by the Benefits &amp; Wellness Department.</td>
<td>Signed Notification or Medical Plan Termination form.</td>
<td>Cancellation cannot be made retroactively. Premiums paid for current coverage will not be refunded.</td>
</tr>
<tr>
<td>Divorce or Termination of Partnership</td>
<td>30 days from date of final divorce or termination of partnership.</td>
<td>End of the month following divorce or termination of partnership.</td>
<td>Medical Plan Termination form.</td>
<td>Cancellation cannot be made retroactively. Premiums paid for current coverage will not be refunded.</td>
</tr>
<tr>
<td>Death of a dependent</td>
<td>30 days from date of death.</td>
<td>End of the month following death.</td>
<td>Medical Plan Termination form or copy of death certificate.</td>
<td>Cancellation cannot be made retroactively.</td>
</tr>
<tr>
<td>Loss of dependent’s eligibility</td>
<td>30 days from date of loss of dependency.</td>
<td>End of the month following loss of dependency.</td>
<td>Medical Plan Termination form.</td>
<td>Premiums paid for current coverage will not be refunded.</td>
</tr>
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### STATUS CHANGES (continued)

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<table>
<thead>
<tr>
<th>Event</th>
<th>Time Limit</th>
<th>When &amp; How Effective</th>
<th>Documents Required</th>
<th>Consequences of Missing Time Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turning age 65 and Medicare eligible or becoming Medicare eligible as a disabled person.</td>
<td>Aetna and HAP Senior Plus within 3 months of becoming Medicare eligible. All other plans - within 30 days of becoming Medicare eligible.</td>
<td>Effective date of Medicare coverage. With Aetna and HAP Senior Plus, enrollment effective first of the month following receipt of required documents.</td>
<td>Medical Plan Enrollment Form and copy of Medicare card showing hospital and medical insurance.</td>
<td>Only BCBS and HAP are available. Coverage effective the first of the month following a 90-day waiting period which begins the date enrollment forms are received by the Benefits &amp; Wellness Department. Other carriers are not available until the next open enrollment.</td>
</tr>
<tr>
<td>Moving out of service area.</td>
<td>30 days from date of move.</td>
<td>Plan change effective first of the month following date of move.</td>
<td>Medical plan enrollment form.</td>
<td>Loss of medical insurance coverage. Only BCBS and HAP are available for re-enrollment effective first of the month following a 90-day waiting period which begins the date enrollment forms are received by the Benefits &amp; Wellness Department. Other carriers are not available until the next open enrollment.</td>
</tr>
<tr>
<td>Loss of non-WSU coverage.</td>
<td>30 days from date of loss.</td>
<td>Plan change effective first of the month following date of loss.</td>
<td>Medical plan enrollment form. Proof of loss of non-WSU coverage.</td>
<td>Only BCBS and HAP are available for re-enrollment effective first of the month following a 90-day waiting period which begins the date enrollment forms are received by the Benefits &amp; Wellness Department. Other carriers are not available until the next open enrollment.</td>
</tr>
</tbody>
</table>
ENROLLMENT & DISENROLLMENT INFORMATION

Enrollment
If you want to enroll in Blue Cross Blue Shield (BCBS), Blue Care Network (BCN), Health Alliance Plan HMO (HAP HMO) or DMC Care, please complete the Medical Enrollment form on page 29. If you are including a dependent on your coverage, his/her information needs to be included on the Medical Plan Enrollment form. If you are enrolling in HAP Senior Plus, each Medicare-eligible individual must complete their own individual application. We have included two applications in this booklet (pages 45 through 51). You can join HAP Senior Plus if you are enrolled in Medicare Part A and Medicare Part B and live in the service area (see Medicare Advantage HMO on page 9). However, individuals with End Stage Renal Disease are generally not eligible to enroll in HAP Senior Plus unless they are members of HAP HMO and have been since their dialysis began.

If you are enrolling in Aetna MedicareSM Plan (PPO), an enrollment form needs to be completed for each covered individual (pages 34 through 41). Please note, Aetna MedicareSM Plan (PPO) is available only to individuals with Medicare (Parts A and B). For two-person contracts each person must have Medicare Parts A and B to enroll in the Aetna MedicareSM Plan (PPO) or HAP Senior Plus Plans.

Aetna forms for retirees and surviving spouses should be returned to:
Aetna Medicare Advantage Plans, P.O. Box 14088, Lexington, KY 40512-4088

All other forms, including Aetna enrollees who are LTD recipients, should be returned to:
Wayne State University, Benefits & Wellness Department
5700 Cass Avenue, Suite 3638, Detroit, MI 48202

Disenrollment
If you decide to terminate your BCBS, BCN, HAP HMO, HAP Senior Plus or DMC Care medical insurance coverage through Wayne State University, you must send a letter to the address listed above indicating that you no longer want the coverage or complete the Medical Plan Termination Form on page 31. Your insurance will be canceled at the end of the month in which we receive your note.

To terminate Aetna MedicareSM Plan (PPO) coverage, you must communicate your intentions directly to Aetna (See page 33 for contract information).

Re-enrollment
If you no longer have medical insurance coverage through Wayne State University and you are a retiree or eligible LTD recipient of Wayne State University, you can re-enroll in Blue Cross Blue Shield or Health Alliance Plan with coverage effective on the first of the month following a 90-day waiting period which begins the date enrollment forms are received by Benefits & Wellness. You can enroll in other carriers offered by Wayne State University during our annual open enrollment with coverage effective January 1.

YOUR MEDICAL OPTIONS

The University offers a number of medical coverage options: one traditional fee-for-service plan (BCBS), two health maintenance organizations (BCN and HAP HMO), one preferred provider plan (DMC Care), a Medicare Advantage preferred provider plan (Aetna) and a Medicare Advantage HMO plan (HAP Senior Plus). The options differ in the benefit levels they provide, the doctors and hospitals you can use, and the cost.

Health Maintenance Organizations (HMOs)

Two to Choose From
You can enroll in one of two HMO’s: HAP or Blue Care Network (BCN).

HMO’s offer broad coverage including preventive care, office visits and prescription drugs at a lower overall out-of-pocket cost.

This coverage is coordinated with Medicare.

Providers
If you elect an HMO, you must choose a primary care physician to manage all of your medical care. Out-of-Network care is not covered except in emergencies or with a written referral from your primary care physician and approval from the HMO. This is a major consideration if you live outside the HMO area.
HAP Senior Plus is a Medicare Advantage plan that provides benefits offered by Medicare Parts A and B, plus additional enhanced benefits (more preventive services, eye and hearing exams and pharmacy benefits) in one plan. If you select HAP Senior Plus, you only need to show your HAP Senior Plus ID card. You will not need to show your Medicare card when you obtain services.

Providers
HAP Senior Plus has a large provider network. If you elect HAP Senior Plus, you must choose a personal care physician to manage all of your medical care. Out-of-Network care is not covered except in emergencies, urgent care or dialysis (out-of-area) or with a written referral from your personal care physician.

HAP Senior Plus has its own provider directory listing doctors, hospitals and other facilities in its network. Contact the HMO directly (see page 12) to receive a current provider directory or search on-line for a provider directory.

Important
HMO participating providers are always subject to change. Before enrolling in a new HMO, check the provider directory to make sure it includes a doctor of your choice. Better yet, call the physician or the HMO just in case there has been a change since the directory was published.

Medicare Advantage HMO
HAP Senior Plus is a Medicare Advantage plan that provides benefits offered by Medicare Parts A and B, plus additional enhanced benefits (more preventive services, eye and hearing exams and pharmacy benefits) in one plan. If you select HAP Senior Plus, you only need to show your HAP Senior Plus ID card. You will not need to show your Medicare card when you obtain services.

Important
Participating providers are always subject to change. Before enrolling you may want to check the provider directory to make sure it includes a doctor of your choice. Better yet, call the physician or HAP Senior Plus just in case there has been a change since the directory was published.
Medicare Advantage Preferred Provider Organization

The Medicare Advantage Preferred Provider Organization plan, or Aetna Medicare℠ Plan (PPO) provides benefits offered by Medicare Parts A and B, plus additional enhanced benefits (more preventive services, eye and hearing exams, hearing aids and pharmacy benefits) in one plan. If you select Aetna Medicare℠ Plan (PPO), you only need to show your Aetna Medicare℠ Plan (PPO) ID card. You will not need to show your Medicare card when you obtain services.

Providers
Aetna Medicare℠ Plan (PPO) gives you the ability to choose your health care provider. However, not all providers may accept this plan, even Medicare providers may not accept this plan. If you choose this plan, it is very important that the providers you choose know before providing services to you that you have Aetna Medicare℠ Plan (PPO) coverage in place of Medicare. This gives your provider the right to choose whether or not to accept Aetna Medicare℠ Plan (PPO) terms and conditions of payment for treating you. Providers have the right to decide if they will accept Aetna Medicare℠ Plan (PPO) each time they see you. This is why you must show your Aetna Medicare℠ Plan (PPO) ID card every time you visit a health care provider.

Claim Forms
You do not need to file claim forms. When seeing a physician, present your ID card and your physician’s office will bill Aetna for your service.

Annual Deductible
There are no deductibles to meet before the plan begins to cover expenses.

Locations
The Aetna Medicare℠ Plan (PPO) has a large national network of Aetna Medicare providers. You have flexibility to see providers either in or out of the plan’s network. PPO members can go to any Medicare-approved provider in the United States who accepts the Aetna Medicare℠ Plan (PPO) regardless of your residence. Since all services are combined into one plan, you will receive a PPO ID card that provides access to all benefits, both medical and pharmacy.

Prescription Drug Coverage
Aetna Medicare℠ Plan (PPO) features a standard formulary:

- Tier one includes preferred generic prescription drugs
- Tier two includes non-preferred generic prescription drugs
- Tier three includes preferred brand name prescription drugs
- Tier four includes non-preferred brand name prescription drugs
- Tier five includes specialty tier generic and brand name drugs

Your plan includes a reduced copay on some generic drugs, called SelectCare Generics. These generic drugs provide cost-effective options to treat high blood pressure, high cholesterol and diabetes. The list of SelectCare generic drugs can be found in the Medicare formulary guide. Selectcare Generics will be covered under tier 1 generics and they will pay up to the tier 1 co-pay. No changes to the drug list for Selectcare Generics.

You can refer to the Aetna Medicare℠ Plan (PPO) group formulary for more information on the tiers for specific drugs. For information on the Aetna Medicare Plan visit www.aetnamedicare.com/group/group_plans_intro.jsp

Flexible Managed Care
DMC Care offers flexibility because it offers features of both a traditional health plan and a managed care plan. Therefore, you will have more freedom in making choices in your health care, a larger provider network (more physicians from which to choose), the ability to see a specialist without obtaining a referral from your physician, and coverage for services both in-network and out-of-network. Please note coverage for services out-of-network are at a reduced level (see comparison chart on pages 14-19).
**DMC CARE (Preferred Provider Organization or PPO) (continued)**

**Annual Deductible**
There are no deductibles to meet for in-network services. There is an out-of-network deductible of $500 per individual and maximum of $1,000 per family.

**Blue Cross Blue Shield (Traditional Fee-For-Service)**
This option may interest you if you want complete flexibility in choosing physicians. The Blue Cross Blue Shield of Michigan traditional coverage will differ depending on whether you are entitled to Medicare.

**Individuals Entitled to Medicare**
There is no annual deductible. The BCBS supplemental coverage is designed to cover the Medicare Part A and B deductibles and coinsurance. Coverage includes inpatient hospitalization, surgical fees, emergency care, and many outpatient procedures including diagnostic testing and prescription drugs. There is no coverage for office visits.

**Individuals Not Entitled to Medicare**
After the $100 per individual/$200 per family annual deductible, most services are covered at 90%. BCBS traditional covers inpatient hospitalization, surgical fees, emergency care, outpatient procedures including diagnostic testing, office visits and prescription drugs. There is no coverage for routine exams, immunizations or screening tests such as pap smears, mammograms or prostate cancer screenings.

---

**PRESCRIPTION DRUG INFORMATION**

**Prescription Drug/Mail Order Information**
Subscribers often have questions about the differences between generic drugs and their brand-name equivalents. We hope you find the following information helpful.

1. **What are generic drugs?**
   A generic drug is identical, or bioequivalent to a brand-name drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use.

2. **Are generic drugs as safe as brand-name drugs?**
   Health professionals and consumers can be assured that Food and Drug Administration (FDA) approved generic drugs have met the same rigid standards as the brand-name drug. To gain FDA approval, a generic drug must:
   - contain the same active ingredients as the brand-name drug (inactive ingredients may vary);
   - be identical in strength, dosage form, and route of administration;
   - have the same use indications;
   - be bioequivalent;
   - meet the same batch requirements for identity, strength, purity, and quality, and be manufactured under the same strict standards of FDA's good manufacturing practice regulations required for brand-name products.

3. **Why are generic drugs less expensive?**
   Generic drugs are less expensive because generic manufacturers do not have the investment costs - including research, development, marketing, and promotion- of the developer of a new drug. In addition, once generic drugs are approved, there is greater competition, which keeps the price down. In fact, brand-name firms are linked to an estimated 50 percent of generic drug production. They frequently make copies of their own or other brand-name drugs but sell them without the brand-name.

4. **If brand-name drugs and generic drugs have the same active ingredients, why do they look different?**
   In the United States, trademark laws do not allow a generic drug to look exactly like the brand-name drug. However, a generic drug must duplicate the active ingredient. Colors, flavors, and certain other inactive ingredients may be different.
**Mail Order Prescription Drugs**

Our plans offer mail order pharmacy services. Mail service saves time and money by eliminating monthly trips to the pharmacy. If you use the same medication daily, then it is probably a maintenance drug. Maintenance drugs are those prescription drugs that your doctor anticipates will be required for at least six months to treat a chronic condition such as arthritis, high cholesterol, depression, high blood pressure, diabetes and ulcers, for example.

By working with your doctor, you can get a 3-month supply of your medication for the cost of one copay. *Please Note:* Aetna Medicare℠ Plan (PPO) provides a 3-month supply of your medication for the cost of two copays. HAP HMO offers a $5 discount off of a 3-month supply. HAP Senior Plus members pay just 2 copays for generic drugs and 2 1/2 copays for all other drugs when purchasing a 3-month supply.

To take advantage of the mail order service most health care programs require you to register by completing a member profile to establish an account. Enrollment forms are available online or by mail by contacting the provider (see table below).

We direct you to the following customer service departments for full information and directions on how to take advantage of the mail order services available with our different health care providers.

<table>
<thead>
<tr>
<th>Health Care Provider</th>
<th>Retail Provider</th>
<th>Mail Order Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Care Network</td>
<td>Blue Care Network (800) 229-0832</td>
<td>Express Script (800) 229-0832</td>
</tr>
<tr>
<td>Blue Cross Blue Shield</td>
<td>Blue Cross Blue Shield (877) 790-2583</td>
<td>Express Script (800) 778-0735</td>
</tr>
<tr>
<td>DMC Care</td>
<td>CVS Caremark (888) 797-8903</td>
<td>CVS Caremark (888) 797-8903</td>
</tr>
<tr>
<td>HAP HMO and HAP Senior Plus (hmo)</td>
<td>Health Alliance Plan HMO (800) 422-4641</td>
<td>Pharmacy Advantage (800) 456-2112</td>
</tr>
<tr>
<td>HAP Senior Plus (hmo)</td>
<td>HAP Senior Plus (800) 801-1770 TTY/TDD 711</td>
<td></td>
</tr>
<tr>
<td>Aetna Medicare℠ Plan (PPO)</td>
<td>Aetna (888) 267-2637</td>
<td>Aetna (888) 792-3862</td>
</tr>
</tbody>
</table>

**TO ORDER PHYSICIAN DIRECTORIES AND ID CARDS**

Medical ID cards are mailed directly from your medical insurance carrier.

**For information or provider directories call... or visit the website...**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Group Number</th>
<th>Telephone Number</th>
<th>Web Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blue Shield (BCBS)</td>
<td>007002779-0004</td>
<td>(877) 790-2583</td>
<td><a href="http://www.bcbsm.com">www.bcbsm.com</a></td>
</tr>
<tr>
<td>DMC Care (DMC)</td>
<td>WSUDMC</td>
<td>(800) 543-0161</td>
<td>(for provider directories) <a href="http://www.dmc-care.org/hsu">www.dmc-care.org/hsu</a></td>
</tr>
<tr>
<td>Blue Care Network (BCN)</td>
<td>00111308-0003-0005</td>
<td>(800) 662-6667</td>
<td><a href="http://www.bcbsm.com">www.bcbsm.com</a></td>
</tr>
<tr>
<td>HAP HMO</td>
<td>10000664-1001</td>
<td>(313) 872-8100</td>
<td>(800) 422-4641 TTY/TDD 711 <a href="http://www.hap.org">www.hap.org</a></td>
</tr>
<tr>
<td>HAP Senior Plus (hmo)</td>
<td>10000664-1006</td>
<td>(313) 664-7015 or (800) 801-1770 711 <a href="http://www.hap.org">www.hap.org</a></td>
<td></td>
</tr>
<tr>
<td>Aetna Retirees LTD</td>
<td>430700</td>
<td>(800) 307-4830 – pre-enrollment <a href="http://www.aetnaretireeplans.com">www.aetnaretireeplans.com</a></td>
<td></td>
</tr>
<tr>
<td>Automated Benefit Services (ABS)</td>
<td>N/A</td>
<td>(800) 645-9978 (for DMC Care ID cards) <a href="http://www.abs-tpa.com">www.abs-tpa.com</a></td>
<td></td>
</tr>
</tbody>
</table>

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QUESTIONS TO CONSIDER BEFORE CHOOSING YOUR MEDICAL OPTION

Before selecting a medical option, review the Comparison of Medical Benefits Chart on pages 14 through 19. It is important to consider your needs and financial situation carefully. Here are some questions to consider:

**How often do you need medical care?**
If you are healthy, you may not need the same type of coverage as someone with recurring health problems.

**What medical expenses do you know you and your dependents will have?**
When choosing coverage, consider a planned surgery or any conditions that need ongoing medical attention such as diabetes and high blood pressure.

**Do you already have a doctor?**
When you join a HMO, you choose a primary care physician for yourself and each covered dependent. All coverage is limited to doctors who participate in that HMO. HMO benefits are generally higher, but you do give up some flexibility in choosing providers.

**What is your financial situation?**
How much can you afford to pay in deductibles and copayments for medical care. Review each plan’s annual deductible, copays and out-of-pocket maximum. Then compare them with how much you pay for the coverage.

FORMS

We have enclosed all the necessary enrollment forms in the back of this handbook. If you need additional forms, please contact us.

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<td>Helpful Hints for Completing the Aetna Enrollment Form .....................................</td>
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<td>WSU Access ID Services (and Online Request Form) for Wayne State Retirees ........</td>
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For non-Aetna, please return completed forms to the Benefits & Wellness Department, 5700 Cass, Suite 3638, Detroit, MI 48202 or fax to (313) 577-0637. Return Aetna Medicare℠ Plan (PPO) Enrollment Forms directly to Aetna at Aetna Medicare Advantage Plans, P.O. Box 14088, Lexington, KY 40512-4088. LTD recipients, please return your forms (including Aetna Medicare℠ Plan (PPO)) to Benefits & Wellness.

Please note that Aetna and HAP Senior Plus require original enrollment forms and will not accept faxes.
## Comparison of Medical Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Blue Cross Blue Shield Without Medicare A &amp; B</th>
<th>Blue Cross Blue Shield With Medicare A &amp; B</th>
<th>Aetna Medicare Open™ Plan (PPO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days of Care</td>
<td>Unlimited</td>
<td>365 Days</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Room Type</td>
<td>Semi-private</td>
<td>Semi-private</td>
<td>Semi-private</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>Pays 90% of approved amount after deductible; non-emergency services must be rendered in a participating hospital</td>
<td>Pays Medicare’s inpatient deductible coinsurance, extends inpatient days to 365. Pays Annual Part B deductible/coinsurance; non-emergency services must be rendered in a participating hospital</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Surgery, Technical Surgical Assistance, Anesthesia, Medical Care</td>
<td>Pays 90% of approved amount after deductible</td>
<td>Pays Medicare deductible/coinsurance</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Office Visits</td>
<td>Pays 90% of approved amount after deductible</td>
<td>Not Covered</td>
<td>$15 copay for each office visit</td>
</tr>
<tr>
<td>Routine Physical Examinations and Screenings</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Eye Examinations</td>
<td>Covered for disease or injury of eye and following cataract surgery. Pays 90% of approved amount after deductible</td>
<td>Routine Eye Exams Not Covered</td>
<td>Covered in full (one annual exam)</td>
</tr>
<tr>
<td>Laboratory and Pathological Services</td>
<td>Pays 90% of approved amount after deductible excluding screening procedures such as Pap smears, prostate screenings, etc</td>
<td>Covered in full</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Radiological Services (X-rays)</td>
<td>Pays 90% of approved amount after deductible excluding miniature x-rays and screening procedures such as mammograms</td>
<td>Pays Medicare deductible/coinsurance</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Allergy Testing and Injections</td>
<td>Pays 90% of approved amount after deductible</td>
<td>Not Covered</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Outpatient Physical, Speech and Occupational Therapy</td>
<td>Pays 90% of approved amount after deductible</td>
<td>Pays Medicare deductible/coinsurance when services rendered in a Blue Cross approved facility. (Not covered in a doctor’s office)</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Durable Medical Equipment &amp; Supplies as prescribed by a physician</td>
<td>With doctor’s prescription pays 90% of approved amount after deductible</td>
<td>Pays Medicare deductible/coinsurance</td>
<td>15% coinsurance</td>
</tr>
</tbody>
</table>

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### Benefits Summary for DMC Care Out-of-Network, HAP HMO, HAP Senior Plus, and Blue Care Network

<table>
<thead>
<tr>
<th>DMC Care In-Network</th>
<th>DMC Care Out-of-Network</th>
<th>HAP HMO</th>
<th>HAP Senior Plus</th>
<th>Blue Care Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Semi-private</td>
<td>Semi-private</td>
<td>Semi-private</td>
<td>Semi-private</td>
<td>Semi-private</td>
</tr>
<tr>
<td>Covered in full</td>
<td>Pays 70% of DMC Care Fee Schedule after deductible</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Covered in full</td>
<td>Pays 70% of DMC Care Fee Schedule after deductible</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
<tr>
<td>$10 copay for each office visit</td>
<td>Pays 70% of DMC Care Fee Schedule after deductible</td>
<td>$10 copay for each office visit</td>
<td>$10 copay for each office visit</td>
<td>$10 copay for each office visit</td>
</tr>
<tr>
<td>$10 copay for each office visit</td>
<td>Not Covered</td>
<td>$10 copay for each office visit</td>
<td>Covered in full</td>
<td>$10 copay for each office visit</td>
</tr>
<tr>
<td>$10 copay for each office visit</td>
<td>Covered for disease or injury of eye and following cataract surgery. Pays 70% of DMC Care Fee Schedule after deductible</td>
<td>$10 copay for each office visit</td>
<td>$10 copay for each office visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Covered in full</td>
<td>Pays 70% of DMC Care Fee Schedule after deductible</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Covered in full</td>
<td>Pays 70% of DMC Care Fee Schedule after deductible</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Covered in full</td>
<td>Pays 70% of DMC Care Fee Schedule after deductible</td>
<td>$10 office visit copay may apply</td>
<td>$10 office visit copay may apply</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Covers 60 visits per year</td>
<td>Pays 70% of DMC Care Fee Schedule after deductible</td>
<td>Covers up to 60 combined visits per year</td>
<td>Covered</td>
<td>$10 office visit copay may apply. 60 visits per episode per year.</td>
</tr>
<tr>
<td>Covered in full</td>
<td>Pays 70% of DMC Care Fee Schedule after deductible</td>
<td>Covered for authorized equipment</td>
<td>Covered in full for authorized equipment</td>
<td>Covered in full</td>
</tr>
</tbody>
</table>

This comparison of benefits is intended to be an easy-to-read summary and review – not a contract. In the event of conflicting information, the plan documents will prevail.
## Comparison of Medical Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Blue Cross Blue Shield Without Medicare A &amp; B</th>
<th>Blue Cross Blue Shield With Medicare A &amp; B</th>
<th>Aetna Medicare℠ Plan (PPO)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>*$10 copay for 30-day supply; Mail-order prescriptions available</td>
<td>*$10 copay for 30-day supply; Mail-order prescriptions available</td>
<td>SelectCare Generics&lt;br&gt;Five Tier prescription plan (see Aetna prescription drug chart on page 20)&lt;br&gt;Part B drugs covered in full</td>
</tr>
<tr>
<td><strong>Outpatient Mental Health Care</strong></td>
<td>Pays 90% of reasonable charge after deductible has been met.</td>
<td>Pays Medicare deductible/coinsurance</td>
<td>$15 copay</td>
</tr>
<tr>
<td><strong>Outpatient Substance Abuse Treatment</strong></td>
<td>Pays 90% of reasonable charge after deductible.</td>
<td>Pays Medicare deductible/coinsurance</td>
<td>$15 copay</td>
</tr>
<tr>
<td><strong>Inpatient Mental Health Care</strong></td>
<td>Pays 90% of reasonable charge after deductible has been met.</td>
<td>Pays Medicare deductible/coinsurance</td>
<td>Covered in full.</td>
</tr>
<tr>
<td><strong>Inpatient Substance Abuse</strong></td>
<td>Pays 90% of reasonable charge after deductible has been met.</td>
<td>Pays Medicare deductible/coinsurance</td>
<td>Covered in full.</td>
</tr>
<tr>
<td><strong>Eyeglasses and Contact Lenses</strong></td>
<td>Pays 90% of reasonable charge after deductible has been met following cataract surgery, intraocular surgery, accidental injury or certain non-routine diagnoses.</td>
<td>Pay Medicare deductible/coinsurance following cataract surgery, intraocular surgery, accidental injury or certain non-routine diagnoses.</td>
<td>Exam 100%&lt;br&gt;One Annual Eyewear/Lens Discount</td>
</tr>
<tr>
<td><strong>Hearing Test</strong></td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered in full</td>
</tr>
<tr>
<td><strong>Hearing Aids</strong></td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered in full up to $500 every 36 months</td>
</tr>
</tbody>
</table>

* Please note the Prescription Drug Program is a PPO arrangement. Member pays only the copayment when prescription is filled at a network pharmacy. If a non-network pharmacy is used, member is responsible for 25% of approved charges in addition to copayment. Program also includes generic drug program requiring generic drug be dispensed (when available) unless doctor indicates “Dispense As Written” (DAW) on prescription.

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<table>
<thead>
<tr>
<th><strong>DMC Care In-Network</strong></th>
<th><strong>DMC Care Out-of-Network</strong></th>
<th><strong>HAP HMO</strong></th>
<th><strong>HAP Senior Plus</strong></th>
<th><strong>Blue Care Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>$5 copay for generic; $10 copay for brand; Mail-order prescriptions available</td>
<td>Reimbursed at 100% of amount paid minus applicable copay. Limited to one month supply.</td>
<td>$5 Generic copay per prescription; $10 Brand copay per prescription Mail-order prescriptions available.</td>
<td>$5 Generic copay per prescription; $10 Brand copay per prescription Mail-order prescriptions available.</td>
<td>$5 copay for generic; $10 copay for brand; Mail-order prescriptions available.</td>
</tr>
<tr>
<td>Covered at 100%. Must be pre-authorized through Value Options</td>
<td>Pays 70% of DMC Care Fee Schedule after deductible has been met. Must be pre-authorized.</td>
<td>$10 copay for each office visit.</td>
<td>$10 copay for each office visit. Covered according to Medicare guidelines.</td>
<td>$10 copay for each visit.</td>
</tr>
<tr>
<td>Covered at 100%. Must be pre-authorized through Value Options</td>
<td>Pays 70% of DMC Care Fee Schedule after deductible has been met. Must be pre-authorized.</td>
<td>$10 copay for each office visit.</td>
<td>$10 copay for each office visit. Covered according to Medicare guidelines.</td>
<td>$10 copay for each office visit.</td>
</tr>
<tr>
<td>Covered at 100%. Must be pre-authorized through Value Options</td>
<td>Pays 70% of DMC Care Fee Schedule after deductible has been met.</td>
<td>Covered at 100%.</td>
<td>Covered at 100% according to Medicare guidelines.</td>
<td>Covered at 100%.</td>
</tr>
<tr>
<td>Covered at 100%. Must be pre-authorized through Value Options</td>
<td>Pays 70% of DMC Care Fee Schedule after deductible has been met.</td>
<td>Covered at 100%.</td>
<td>Covered at 100% according to Medicare guidelines.</td>
<td>Covered at 100%.</td>
</tr>
<tr>
<td>Covered in full following cataract surgery or intraocular surgery</td>
<td>Not covered except following cataract surgery or intraocular surgery. Pays 70% after deductible has been met.</td>
<td>Not Covered (except following Cataract or intraocular surgery according to plan guidelines.)</td>
<td>Not Covered (except following Cataract or intraocular surgery according to plan guidelines.)</td>
<td>Covered in full following cataract surgery or to replace an organic lens because of congenital absence. Only the initial prescription is covered.</td>
</tr>
<tr>
<td>Covered with office copay</td>
<td>Pays 70% after deductible has been met</td>
<td>Covered with $10 office visit copay</td>
<td>Covered with $10 office visit copay</td>
<td>Covered with office copay</td>
</tr>
<tr>
<td>One hearing aid covered in full up to $1,000 every 36 months</td>
<td>Pays 70% after deductible has been met. One hearing aid covered at up to $1,000 every 36 months.</td>
<td>Covered for authorized conventional hearing aids</td>
<td>Covered for authorized conventional hearing aids</td>
<td>Covered according to plan guidelines: One hearing aid every 36 months.</td>
</tr>
</tbody>
</table>

This comparison of benefits is intended to be an easy-to-read summary and review – not a contract. In the event of conflicting information, the plan documents will prevail.
## Comparison of Medical Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Blue Cross Blue Shield Without Medicare A &amp; B</th>
<th>Blue Cross Blue Shield With Medicare A &amp; B</th>
<th>Aetna Medicare™ Plan (PPO)</th>
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<tbody>
<tr>
<td>Emergency Services (Life-Threatening Medical Emergencies or Accidents ONLY)</td>
<td>Pays 90% of approved amount after deductible</td>
<td>Pays Medicare deductible/coinsurance</td>
<td>Covered in full after copay: Urgent Care Provider $15 copay&lt;br&gt;Emergency Room $50 copay;&lt;br&gt;(waived if admitted)&lt;br&gt;Ambulance $15 copay</td>
</tr>
<tr>
<td>Skilled Nursing Care Facility</td>
<td>Not Covered</td>
<td>Pays Medicare daily coinsurance for 21st through 100th day.</td>
<td>Day 1-20 100%&lt;br&gt;Day 21-100 $75 copay per day&lt;br&gt;100 day maximum per Medicare benefit period</td>
</tr>
<tr>
<td>Annual Deductibles</td>
<td>$100 per person&lt;br&gt;$200 per family</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Copays</td>
<td>10% unless otherwise noted, $10 prescription copay</td>
<td>$10 prescription copay</td>
<td>$15 office visit,&lt;br&gt;Urgent care, ambulance, outpatient MH/SA&lt;br&gt;$50 emergency room (waived if admitted)&lt;br&gt;15% coinsurance DME&lt;br&gt;Five tier prescription plan (see Aetna prescription drug plan on page 20)</td>
</tr>
<tr>
<td>Annual Maximum Out-of-Pocket (Includes deductible, coinsurance and copays)</td>
<td>10% coinsurance is limited to $500 per person per year&lt;br&gt;($1,000 per family). All cost sharing limited to $600 individual, $1,200 family</td>
<td>$0</td>
<td>$2,000 Copays accumulate towards annual out of pocket (excluding prescription copays)</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Hospital Pre-Certification</td>
<td>Required - physician responsibility</td>
<td>Required - physician responsibility</td>
<td>Not Required</td>
</tr>
</tbody>
</table>

2017 Plan Year  
www.wayne.edu/hr/tcw
<table>
<thead>
<tr>
<th>Benefits</th>
<th>DMC Care In-Network</th>
<th>DMC Care Out-of-Network</th>
<th>HAP HMO</th>
<th>HAP Senior Plus</th>
<th>Blue Care Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full. Should notify primary care physician or health plan within 48 hours of admission.</td>
<td>Covered up to 730 days, renewable after 60 days, excludes custodial care</td>
<td>Covered in full. Must notify primary care physician or health plan within 48 hours of admission.</td>
</tr>
<tr>
<td>Covered in full up to 365 days per lifetime, excludes custodial care</td>
<td>Pays 70% of DMC Care Fee Schedule after deductible has been met, up to 365 days per lifetime, excludes custodial care</td>
<td>Covered up to 730 days, renewable after 60 days, excludes custodial care</td>
<td>Covered up to 730 days per benefit period, excludes custodial care</td>
<td>730 days per episode of illness, excludes custodial care</td>
<td></td>
</tr>
<tr>
<td>$0</td>
<td>$500 per individual per calendar, $1,000 per family per calendar year.</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>$10 office visit, $5 copay generic drugs, $10 copay brand name drugs</td>
<td>30% unless otherwise noted. $5 copay generic drugs, $10 copay brand drugs</td>
<td>$10 office visit, $5 copay generic drugs, $10 copay brand name drugs</td>
<td>$10 office visit, $5 copay generic drugs, $10 copay brand name drugs</td>
<td>$10 office visit, $5 copay generic drugs, $10 copay brand name drugs except drugs for fertility treatment</td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>Medical</td>
<td>Medical</td>
<td>Medical</td>
<td>Medical</td>
<td></td>
</tr>
<tr>
<td>$5,000 individual</td>
<td>$5,000 individual</td>
<td>$6,350 individual</td>
<td>$6,700</td>
<td>$6,350 individual</td>
<td></td>
</tr>
<tr>
<td>$10,000 family</td>
<td>$10,000 family</td>
<td>$12,700 family</td>
<td></td>
<td>$12,700 family</td>
<td></td>
</tr>
<tr>
<td>Prescription</td>
<td>Prescription</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$1,600 individual</td>
<td>$1,600 individual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$3,200 family</td>
<td>$3,200 family</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td>Required - physician responsibility</td>
<td>Required - member responsibility</td>
<td>Required for each admission and emergency care in a non-participating hospital within 48 hours; Check plan for details</td>
<td>Required for each admission, check plan for details</td>
<td>Required for emergency care in a nonparticipating hospital within 48 hours</td>
<td></td>
</tr>
</tbody>
</table>

This comparison of benefits is intended to be an easy-to-read summary and review – not a contract. In the event of conflicting information, the plan documents will prevail.
WOMEN'S HEALTH AND CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under each of the University-sponsored medical plans.

AETNA PRESCRIPTION DRUG CHART

<table>
<thead>
<tr>
<th>Tier</th>
<th>Retail</th>
<th>Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1*</td>
<td>$2</td>
<td>$4</td>
</tr>
<tr>
<td>Tier 2*</td>
<td>$10</td>
<td>$20</td>
</tr>
<tr>
<td>Tier 3*</td>
<td>$40</td>
<td>$80</td>
</tr>
<tr>
<td>Tier 4*</td>
<td>$75</td>
<td>$150</td>
</tr>
<tr>
<td>Tier 5*</td>
<td>33% coinsurance</td>
<td>33% coinsurance</td>
</tr>
</tbody>
</table>

Retail and Mail-Order up to the Initial Coverage Limit (ICL) of $3,700

<table>
<thead>
<tr>
<th>Tier</th>
<th>Retail</th>
<th>Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>$2</td>
<td>$4</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$10</td>
<td>$20</td>
</tr>
<tr>
<td>Tier 3,4,&amp;5 generic</td>
<td>51% coinsurance</td>
<td>51% coinsurance</td>
</tr>
<tr>
<td>Tier 3,4,&amp;5 brand</td>
<td>40% coinsurance</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>

Retail and Mail-Order between the ICL and coverage gap of $4,950

Catastrophic (after coverage gap of $4,950)

Greater of $3.30 or 5% for covered generic (including brand drugs treated as generic) drugs. Greater of $8.25 or 5% for all other covered drugs.

*Tier 1 = Preferred Generic; Tier 2 = Non Preferred Generic; Tier 3 = Preferred Brand; Tier 4 = Non Preferred Brand; Tier 5 = Specialty Medications; (See more detail on page 10)
MEDICARE INFORMATION

Medicare is a federal health insurance program which is generally available to people age 65 or older. It might also be available before age 65 for certain disabled individuals, or persons with end-stage renal disease (chronic kidney failure). Medicare is administered by the Centers for Medicare and Medicaid Services. You can obtain information or sign up for Medicare through your local Social Security Administration office.

These days you can get Medicare health care and prescription drug coverage in different ways.

- Original Medicare Plan
- Medicare Advantage Plans and other Medicare Health Plans
- Medicare Prescription Drug Plans (PDP)

The Original Medicare Plan has two parts:

**Medicare Part A** (Hospital Insurance) helps cover your inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. You must meet certain conditions to get these benefits. Most people do not have to pay for Part A.

**Medicare Part B** (Medical Insurance) helps cover your doctors’ services and outpatient care. It also covers other medical services that Part A doesn’t cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary. Most people pay a monthly premium for Part B.

**Medicare Advantage Plan Part C**

Medicare Advantage Plans are private health plans that replace your traditional Medicare coverage. If you join one of these plans, you generally get all your Medicare-covered health care through the plan and most include prescription drug coverage. In most of these plans, there are extra benefits and lower co-payments than in the Original Medicare Plan. However, you may have to see doctors that belong to the plan or go to certain hospitals to get services. You must continue to pay the Medicare Part B premium if you elect a Medicare Advantage Plan. You do not need to show your Medicare card.

**Medicare Advantage Preferred Provider Organization Plans**

The Aetna Medicare℠ Plan (PPO) provides benefits offered by Medicare Parts A and B, plus additional enhanced benefits (more preventive care services, eye and hearing exams, and pharmacy benefits) in one plan. PPO members must ensure their provider will accept the PPO plan. And since the plan has an Extended Service Area, you won’t pay a higher cost share when receiving covered services from non-network providers. You will receive all covered services at the in-network cost share—unlike typical PPO plans.

**What you can rely on with the PPO**

You’ll enjoy a plan with limits on your out-of-pocket costs. You’ll have coverage for preventive benefits beyond Original Medicare and you choose your providers.

**Medicare Advantage HMO**

Medicare Health Maintenance Organization (HMO) plans provide benefits offered by Medicare Parts A and B, plus additional enhanced benefits (more preventive care services, eye and hearing exams, and pharmacy benefits) in one plan. HMO members are required to select a personal care physician (PCP) within the HMO network to manage their health care. There is no coverage for services that are not coordinated by the personal care physician (except urgent and emergency care).
Medicare Prescription Drug Coverage (Part D)

Medicare prescription drug coverage became available to everyone with Medicare as of January 1, 2006. Medicare prescription drug coverage helps cover your prescription drug costs. You choose the drug plan (provided by a private company) and you pay a monthly premium. If you have limited income and resources, you may get this coverage for little or no cost. Medicare drug plans will cover generic and brand-name drugs. Plans may have rules about what drugs are covered in different drug categories. This ensures that people with different medical conditions can get the treatment they need. Most plans will have a formulary, which is a list of drugs covered by the plan. This list must always meet Medicare’s requirements, but it can change when plans get new information.

Medicare helps employers continue to provide retiree drug coverage that meets Medicare’s standards. If you currently have prescription drug coverage through an employer that is, on average, at least as good as the minimum standard Medicare prescription drug coverage, you can keep the coverage through an employer instead of enrolling in Medicare prescription coverage. You will have a Special Enrollment Period to sign up for a drug plan if your employer stops offering this coverage.

How WSU Retiree Coverage Interacts With Medicare

WSU Retiree medical coverage is “secondary” to Medicare Parts A and B except the Aetna MedicareSM Plan (PPO) and HAP Senior Plus plan which replaces traditional Medicare. This means Medicare pays benefits before the WSU plan pays. As soon as you or your covered dependent become eligible for Medicare, you or your covered dependent must be enrolled in Medicare Parts A and B to be entitled to all of the benefits provided under your WSU plan. The WSU plan will only pay for services covered by Medicare after Medicare has paid their portion.

IMPORTANT: WSU Retiree prescription drug coverage cannot be coordinated with Medicare prescription drug coverage (i.e. cannot pay on a secondary basis). If you currently have prescription drug coverage through WSU (which has been determined to be at least as good as Medicare prescription drug coverage), you can choose not to enroll in Medicare prescription drug coverage. WSU Retiree coverage is considered “creditable coverage.” If you have creditable coverage and later decide to enroll in a Medicare prescription drug plan, you won’t have to pay a penalty as long as you enroll within 63 days after your creditable coverage ends.

Resources For More Information

My.Medicare.gov

My.Medicare.gov provides you with direct Internet access to your Medicare benefits, eligibility, and preventive health information-24 hours a day, 7 days a week. Visit the site, sign up, and Medicare will mail you a password to allow you access to your personal Medicare information. My.Medicare.gov will also include access to information on your own Medicare claims.

1-800-MEDICARE Helpline

The 1-800-MEDICARE (1-800-633-4227) helpline makes it easy for you to get the information you need 24 hours a day, including weekends. TTY users should call 1-877-486-2048.

State Health Insurance Assistance Program: For help with questions about appeals, buying other insurance, choosing a health plan, buying a Medigap policy, and Medicare rights and protections. If you live in Michigan, call 1-800-803-7174.

Social Security Administration

Call 1-800-772-1213 for address or name changes, death notification, enrolling in Medicare, to replace your Medicare card, and information about Social Security benefits. TTY users should call 1-800-325-0778.
Important Notice to Wayne State University Medical Plan Participants
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Wayne State University and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Wayne State University has determined that the prescription drug coverage offered by the Wayne State University Health Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15 through December 7. Beneficiaries leaving employer/union coverage may be eligible for a two-month Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your Wayne State University medical insurance coverage, be aware that surviving spouses and dependents may not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with Wayne State University and don't enroll in Medicare prescription drug coverage within 63 continuous days after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare’s prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You’ll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.
**As a WSU Retiree, What Are Your Options Under the WSU Medical Insurance Plan?**

Your options are as follows:

<table>
<thead>
<tr>
<th>You can elect to continue your WSU medical insurance coverage and NOT enroll in Medicare Part D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Since WSU medical insurance coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can elect to keep your WSU coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage. Each year from October 15 through December 7, you will have the opportunity to enroll in a Medicare prescription drug plan. However, if you lose your current creditable prescription drug coverage, you will also be eligible for a two-month Special Enrollment Period to join a Medicare prescription drug plan. (Please note you cannot have both WSU medical insurance and a Medicare prescription drug plan. The WSU medical insurance plans do not coordinate with the Medicare prescription drug plans.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>You can choose not to continue your WSU coverage AND enroll in alternative medical and prescription coverage (e.g., a Medigap plan and a Medicare prescription drug plan, or a Medicare Advantage plan).</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you decide to enroll in a Medicare prescription drug plan, you and your eligible dependents will not be eligible for WSU medical insurance coverage. You will want to consider a Medigap or Medicare Advantage plan to replace your WSU coverage. If your spouse is not enrolled in Medicare, you will need to purchase alternative coverage (e.g., individual coverage) for your spouse.</td>
</tr>
<tr>
<td>A retiree who chooses not to continue WSU coverage may re-enroll in WSU coverage during our annual retiree open enrollment in November/December with coverage effective January 1. Said retiree MUST disenroll from any Medicare prescription drug plan. WSU medical insurance plans do not coordinate with Medicare prescription drug plans. Coverage will not be available through Wayne State University for your spouse alone.</td>
</tr>
</tbody>
</table>

**For more information about this notice or your current prescription drug coverage...**

Contact our office at (313) 577-6353. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through Wayne State University changes. You may also request a copy.

**For more information about your options under Medicare prescription drug coverage...**

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.**
NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this notice, please contact the Benefits & Wellness Department at (313) 577-3000.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records
- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information
- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.
NOTICE OF PRIVACY PRACTICES (continued)

File a complaint if you feel your rights are violated
• You can complain if you feel we have violated your rights by contacting us.
• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
• We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
• Share information with your family, close friends, or others involved in payment for your care
• Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
• Marketing purposes
• Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

Run our organization
• We can use and disclose your information to run our organization and contact you when necessary.
• We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Pay for your health services
We can use and disclose your health information as we pay for your health services.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers’ compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.
NOTICE OF PRIVACY PRACTICES (continued)

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.
## Medical Plan Enrollment Form For Retiree/Surviving Spouse/Eligible LTD Recipients

To Enroll, Change Coverage or Add a Dependent

Please print all information.

Your application must be received in the Benefits & Wellness Department within 30 days of the date of event (date of marriage, etc.) or by the communicated deadline for Open Enrollment in order for enrollment to take effect.

If you are adding dependents, proof may be required for your application to be considered complete and enrollment to take effect.

### Retiree / Surviving Spouse / Eligible LTD Recipient Information

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Customer ID</th>
<th>Last Name</th>
<th>First Name</th>
<th>Middle I</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Birth Date</th>
<th>Sex</th>
<th>Date of Retirement</th>
<th>Daytime Phone</th>
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<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address and Street</th>
<th>City and State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Number</th>
<th>Hospital Insurance (Part A) Effective Date</th>
<th>Medical Insurance (Part B) Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Select One Plan Only

Please check the box next to the plan in which you wish to enroll.

- Traditional Medical
  - Blue Cross Blue Shield of Michigan

- Preferred Provider Organization
  - DMC Care

*You must select a primary care physician and complete the physician selection information in the column below.

### Persons to be covered or added

<table>
<thead>
<tr>
<th>Add</th>
<th>Event Date for Additions*</th>
<th>Relationship**</th>
<th>Social Security Number</th>
<th>Last Name</th>
<th>First Name</th>
<th>Birth Date (M-D-Y)</th>
<th>Sex</th>
<th>Physician or Center Code</th>
</tr>
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</tbody>
</table>

*Date of New Marriage, Other Eligible Person Relationship, Court Orders, etc.

**Spouse, Other Eligible Person, Child, Disabled Child, Sponsored Dependent, Senior Rider.

The information listed above is correct to the best of my knowledge. I understand I am responsible for payment of the medical insurance premiums based on the current rates and any future rate increases. I understand that the University may ask me to provide evidence that the eligibility requirements are being met.

I authorize the release of the information listed above to the insurance plan I have selected for the purpose of obtaining coverage. The information will be provided to the insurance plan in electronic format.

Signature: ___________________________  Date Signed: ________________

Please return to: Benefits & Wellness, 5700 Cass Ave., Suite 3638, Detroit, MI 48202; Fax: 313-577-0637

www.wayne.edu/hr/tcw  2017 Plan Year
Medical Plan Termination Form
To Delete a Dependent/Subscriber

Please print all information.

This form must be received in the Benefits & Wellness Department within 30 days of the date of event (date of divorce, loss of dependency, etc.). If the form is received beyond the 30-day period, or is received incomplete, premiums will not be refunded.

You must include the current address of the dependent for the form to be considered complete. The Benefits & Wellness Department will not process the form if it is not complete.

<table>
<thead>
<tr>
<th>Subscriber Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Number</td>
</tr>
<tr>
<td>Address and Street</td>
</tr>
</tbody>
</table>

1. Person to be Deleted (If subscriber terminates, all dependents terminate automatically)

| Social Security Number | Last Name | First Name | Middle Name |
| Address and Street     | Zip Code  | City and State | Birth Date |

Reason for deleting person (other coverage, divorce, loss of dependency, death, etc.) | Date of event (divorce, other coverage, etc.) |

2. Person to be Deleted

| Social Security Number | Last Name | First Name | Middle Name |
| Address and Street     | Zip Code  | City and State | Birth Date |

Reason for deleting person (other coverage, divorce, loss of dependency, death, etc.) | Date of event (divorce, other coverage, etc.) |

3. Person to be Deleted

| Social Security Number | Last Name | First Name | Middle Name |
| Address and Street     | Zip Code  | City and State | Birth Date |

Reason for deleting person (other coverage, divorce, loss of dependency, death, etc.) | Date of event (divorce, other coverage, etc.) |

The information listed above is correct to the best of my knowledge.
I authorize the release of the information listed above to the insurance plan I have selected for the purpose of obtaining coverage. The information will be provided to the insurance plan in electronic format.

Signature | Date Signed

For the Benefits & Wellness Department use only
Effective Date: [31]

2017 Plan Year
www.wayne.edu/hr/tcw
Helpful Hints for Completing the Aetna Enrollment Form

Medicare Member Services (Medical & Rx) – Pre Enrollment:
1-800-307-4830

Medicare Member Services (Medical & Rx) – Post Enrollment:
1-888-267-2637

Medicare Prescription Home Delivery:
1-888-792-3862

website:  www.aetnaretireeplans.com

If you are a Wayne State University retiree or surviving spouse, please return your completed enrollment form(s) to Aetna, P.O. Box 14088, Lexington, KY 40512-4088

If you are an LTD recipient, please return your completed form(s) to Benefits & Wellness, 5700 Cass, Suite 3638, Detroit, Michigan 48202. Enrollment forms cannot be faxed.

Please note two enrollment forms have been included in your Wayne State University Retiree Handbook. If your spouse is also eligible to enroll, he/she will have to complete a separate enrollment form – two separate forms will need to be submitted.

If you are enrolling during the annual open enrollment period, please put the date of 01/01/2017 in the box in the upper right hand corner of the enrollment form.

Note: Reference to dentist name and office ID number should be ignored. WSU Aetna MedicareSM Plan (PPO) does not include dental coverage.

Disenrollment from the Aetna plan can be done at any time in the year. The termination form (Page 31) in the Wayne State University Retiree Handbook must be filled out, signed, and returned to Aetna to complete the disenrollment process.
## Enrollment instructions

**Answer all questions completely. Incomplete or incorrect information may delay the start of your coverage.** Below are the instructions for each section of the enrollment form. You can use this form to enroll or submit a plan change if you're already enrolled.

### Effective date:

Your coverage will begin on the first day of the month after you sign this enrollment form, or the date your enrollment is completed. **The effective date can't be earlier than the day you sign this form.**

### Former employer information:

Write the name of the former employer/union/trust offering this health plan (the company you retired from). List the group number and class code if you know it. The group number and class code number are not required. (This information may be pre-filled.)

### Personal information:

This is your name, address, phone number, etc. **Print clearly.**

### Medicare information:

This is your Medicare insurance information, found on your red, white and blue Medicare Card. Complete all the fields to avoid a delay in your coverage.

### Health plan selection:

Check the box next to the plan you want to enroll in. (there may be only one plan available). For more plan details, look at the benefit summary included in your enrollment packet.

### Select a provider:

For Aetna Medicare Plan (HMO): A primary care physician (PCP) is required. Write in the name of your PCP and their office ID number. You’ll find this is in our provider directory.

For Aetna Medicare Plan (PPO): A primary care physician is **not** required. But if you choose one you may pay less for care. Write the name of your PCP and office ID number.

### Select a dentist:

**For Aetna Medicare Plan (HMO) only:** If DMO dental benefits are included in your plan, a primary dentist is required. Write the name of your Aetna dentist and their office ID number.

### Medicare-related questions:

Read and answer these Medicare questions.

### Read this important section carefully:

DISCLOSURES

### Signature required:

Sign and date the application in the space provided.

### Authorized representatives:

Sign the form and write in your information.

### Make a copy for yourself and mail original:

Make a copy of the entire application for your records. Then mail your completed original form to the address below. A separate enrollment form must be completed for each Medicare-eligible dependent. Two forms may have been included for your convenience.

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak a language other than English, free language assistance services are available. Visit our website at www.aetnamedicare.com or call the phone number listed in this material.

**ESPÁÑOL (SPANISH):** ATENCIÓN: Si usted habla español, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web en www.aetnamedicare.com o llame al número de teléfono que se indica en este material.

**繁體中文 (CHINESE):** 請注意：如果您說中文，您可以獲得免費的語言協助服務。請造訪我們的網站 www.aetnamedicare.com或致電本材料中所列的電話號碼。

Call your former employer/union/trust or Aetna Medicare with any questions.

| Phone number: | 1-800-307-4830 (TTY: 711) |
| Hours: | Monday – Friday, 7 a.m. – 8 p.m. CT |
| Mail to: | Aetna, PO Box 14088, Lexington, KY 40512-4088 |
| Website: | [http://www.aetnaretireeplans.com](http://www.aetnaretireeplans.com) |
| Fax Number | 1-888-665-6296 |

**GRP_1070_728 08/2016** Make a copy for yourself and return the original **GR-68361 (8-16) 2017 R-POD**
**Former employer/union/trust information:** Write the name of the former employer/union/trust offering your retiree health plan unless this information is pre-filled.

<table>
<thead>
<tr>
<th>Name of former employer/union/trust</th>
<th>Group number</th>
<th>Class code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wayne State University Circle One LTD/AE430697 Retiree/AE430700</td>
<td>800</td>
<td></td>
</tr>
</tbody>
</table>

**PERSONAL INFORMATION**

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>Middle initial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Sex**
  - [ ] M
  - [ ] F

- **Home phone number**

- **Birth date**
  - (M/M/DD/YYYY)

- **Permanent residence street address** (PO Box is not allowed)

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP code</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

- **Mailing address (only if different from your permanent residence address)**

- **Email address (optional)**

<table>
<thead>
<tr>
<th>Emergency contact name (optional)</th>
<th>Relationship to you</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Phone number**

- **Cell phone number**

**Medicare information**

- Use your Medicare card to complete this section.
- Fill in these blanks so they match your red, white and blue Medicare card.
- or -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.
- You must have Medicare Part A and Part B to join a Medicare Advantage plan.

**Health plan selection:** Check the box next to the type of plan you want to enroll in. Then write the name of the specific plan on the line provided. (This information may be pre-filled). For more plan details, look at the benefit summary included in your enrollment kit. Make sure to read the important health plan disclosures on Page 4.

- [ ] Aetna Medicare HMO (write plan name below)
- [ ] Aetna Medicare PPO (write plan name below)
- [ ] Aetna Medicare HMO with Rx (write plan name below)
- [ ] Aetna Medicare PPO with Rx (write plan name below)
- Medicare P01 ESA PPO w/ Rx 11S3

**Fill out the following:**

- I'm currently enrolled in a Medicare Advantage plan issued by (insurance company name)
- I'd like to change to an Aetna plan. I understand this plan may have different health benefits and monthly payments than my current plan.

**Select providers:** A primary care physician (PCP) is required for HMO plans and is recommended for FPO plans. (FPO members may pay less by choosing a PCP.) If you choose an HMO plan with DMO dental benefits, you must also choose a dentist. To select a PCP or dentist, look at the Aetna Medicare provider directory or call the phone number on the instruction page.

- **PCP first and last name**
- **PCP office ID**

- **Dentist first and last name**
  - (for HMO plans with DMO dental benefits)
- **Dentist office ID**
  - (for HMO plans with DMO dental benefits)

Make a copy for yourself and return the original

GR-68361 (8-16) 2017
### MEDICARE-RELATED QUESTIONS

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you an Aetna member? If Yes, provide your member ID number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you the retiree? If Yes, provide retirement date (MM/DD/YYYY):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If No, name of retiree:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you covering a spouse or dependents under this employer, trust or union plan?</td>
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<td></td>
</tr>
<tr>
<td>If Yes, name of spouse:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of dependents:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you or your spouse work?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have end-stage renal disease (ESRD)? If you’ve had a successful kidney transplant and/or you don’t need regular dialysis any more, attach a note or records from your doctor showing you’ve had a successful kidney transplant or you don’t need dialysis. Otherwise, we may need to contact you to obtain additional information. If Yes, what is the date of your first dialysis treatment? Date: (month) (year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you become eligible for Medicare because of ESRD and has it been less than 30 months since you became eligible? If so, Medicare Advantage Coverage will be your secondary coverage for the first 30 months of the coordination period. If Yes, provide your prior commercial coverage carrier’s name: Member number: Effective date / /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was your previous policy terminated? If Yes, provide termination date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you a resident in a long-term care facility, such as a nursing home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, provide the following information:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of institution: Phone number: ( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address: State: ZIP:</td>
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<tr>
<td>Are you enrolled in your state Medicaid program? If Yes, provide your Medicaid number:</td>
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Please choose your preferred language:

- Spanish
- Other

Please contact us at the number below if you need information in another language or format (e.g., large print or braille).

This information is available for free in other languages. Please call our customer service number at 1-888-267-2637 (TTY: 711). We’re here 8 a.m. to 6 p.m., local time, Monday through Friday.

**Other Rx coverage:** Complete only if you have other prescription drug coverage.

- Some individuals may have other drug coverage, including other private insurance, workers' compensation, VA benefits or through state pharmaceutical assistance programs.

  **Will you have other prescription drug coverage in addition to the Aetna Medicare Advantage Rx plan?** If Yes, please list your other coverage and identification number(s) for this coverage:

  Name of other coverage: __________________________________________________________________________________________________

  ID #: __________________________________________________________________________ Group #: __________________________________________________________________________

- **Have you had creditable coverage since you became eligible for Medicare prescription drug coverage?**

  If so, from date (MM/DD/YY) ___ to date (MM/DD/YY) ___

  Creditable coverage is prescription drug coverage that is at least as good as Medicare prescription drug coverage.

  **NOTE:** If you’ve not had creditable coverage, you may have to pay a late enrollment penalty. Aetna may ask you to provide evidence of creditable coverage. If you have questions about the late enrollment penalty, call Aetna at the number provided on this form.
Disclosures – Read this section carefully.

By completing this enrollment application, I agree to the following: Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. I will need to keep my Medicare Parts A and B coverage. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. If I’m enrolling in a Medicare Advantage plan without prescription drug coverage (medical benefits only), I understand that if I don’t have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare’s), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available or under certain special circumstances. The Aetna Medicare Advantage plan serves a specific service area. If I move out of the area that Aetna Medicare Advantage plan serves, I need to notify the plan and my former employer/union/trust so I can disenroll and find a new plan in my new area. Once I’m a member of the Aetna Medicare Advantage plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Aetna when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren’t usually covered under Medicare while out of the country except for limited coverage near the U.S. border. I may also be disenrolled if I do not pay any applicable plan premiums within the grace period. The effective date of disenrollment is in accordance with federal requirements. HMO plans - I understand that beginning on the date Aetna Medicare Advantage plan coverage begins, I must get all my health care from the Aetna Medicare Advantage plan, except for emergency or urgently needed services or out of area dialysis services. Services authorized by the Aetna Medicare Advantage plan and other services contained in my Aetna Medicare Advantage plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR THE AETNA MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES. PPO plans: I understand that beginning on the date Aetna Medicare Advantage plan coverage begins, using services in network can cost less than using services out of network, except for emergency or urgently needed services or out of area dialysis services. I understand I can go to doctors, specialists or hospitals in or out of network. I understand providers must be licensed and eligible to receive payment under the federal Medicare program and agree to accept the PPO plan. I also understand I may have to pay more for services I receive out of network. Services authorized by the Aetna Medicare Advantage plan and other services contained in my Aetna Medicare Advantage plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization when required by the plan, NEITHER MEDICARE NOR THE AETNA MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES.

I’ve been advised not to cancel or drop any supplemental insurance I currently have until I receive written notification of my confirmed effective date from Aetna. I understand the providers in the Aetna network are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. I understand if I’m getting assistance from a sales agent, broker, or other individual employed by or contracted with Aetna’s Medicare Advantage plans, he/she may be paid based on my enrollment in the Aetna Medicare Advantage plan. Release of information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Aetna Medicare will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature: ______________________ ___________ ___________ ___________
Representative’s name: _______________ Address: _______________ Phone number: _______________ Relationship to enrollee: _______________

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, provider network, premium and/or co-payments/co-insurance may change on January 1 of each year. You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable. This information is available for free in other languages. Please call our customer service number at 1-888-267-2637 (TTY: 711), 8 a.m. to 6 p.m., local time. Monday through Friday.

Esta información está disponible en otros idiomas de manera gratuita. Comuníquese con Servicios al Cliente al 1-888-267-2637 (TTY: 711). Horario de atención: de 8 a.m. a 6 p.m., hora local, de lunes a viernes.

本資訊也有其他語言的免費版本可供選擇。請致電 1-888-267-2637 與我們的客戶服務部聯絡以了解更多資訊。（聽障人士請致電 711）辦公時間為週一至週五、當地時間上午 8 時至晚間 6 時。

4 of 4
Make a copy for yourself and return the original

GR-68361 (8-16) 2017

www.wayne.edu/hr/tcw
**Enrollment instructions**

Answer all questions completely. Incomplete or incorrect information may delay the start of your coverage. Below are the instructions for each section of the enrollment form. You can use this form to enroll or submit a plan change if you’re already enrolled.

**Effective date:**
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**Former employer information:**
Write the name of the former employer/union/trust offering this health plan (the company you retired from). List the group number and class code if you know it. The group number and class code number are not required. (This information may be pre-filled.)

**Personal information:**
This is your name, address, phone number, etc. **Print clearly.**

**Medicare information:**
This is your Medicare insurance information, found on your red, white and blue Medicare Card. Complete all the fields to avoid a delay in your coverage.

**Health plan selection:**
Check the box next to the plan you want to enroll in. (There may be only one plan available). For more plan details, look at the benefit summary included in your enrollment packet.

**Select a provider:**
For Aetna Medicare Plan (HMO): A primary care physician (PCP) is required. Write in the name of your PCP and their office ID number. You’ll find this is in our provider directory.
For Aetna Medicare Plan (PPO): A primary care physician is not required. But if you choose one you may pay less for care. Write the name of your PCP and office ID number.

**Select a dentist:**
For Aetna Medicare Plan (HMO) only: If DMO dental benefits are included in your plan, a primary dentist is required. Write the name of your Aetna dentist and their office ID number.

**Medicare-related questions:**
Read and answer these Medicare questions.

**Read this important section carefully:**

**DISCLOSURES**

**Signature required:**
Sign and date the application in the space provided.

**Authorized representatives:**
Sign the form and write in your information.

**Make a copy for yourself and mail original:**
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**ESPAÑOL (SPANISH):** ATENCIÓN: Si usted habla español, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web en [www.aetnamedicare.com](http://www.aetnamedicare.com) o llame al número de teléfono que se indica en este material.

**繁體中文 (CHINESE):** 請注意：如果您說中文，您可以獲得免費的語言協助服務。請造訪我們的網站 [www.aetnamedicare.com](http://www.aetnamedicare.com) 或致電本材料中所列的電話號碼。

Call your former employer/union/trust or Aetna Medicare with any questions.

- **Phone number:** 1-800-307-4830 (TTY: 711)
- **Hours:** Monday – Friday, 7 a.m. – 8 p.m. CT
- **Mail to:** Aetna, PO Box 14088, Lexington, KY 40512-4088
- **Website:** [http://www.aetnameretireeplans.com](http://www.aetnameretireeplans.com)
- **Fax Number:** 1-888-665-6296

| GRP_1070_728 08/2016 | Make a copy for yourself and return the original | GR-68361 (8-16) 2017 R-POD | 1 of 4 |
Former employer/union/trust information: Write the name of the former employer/union/trust offering your retiree health plan unless this information is pre-filled.

Name of former employer/union/trust
Wayne State University Circle One LTD/AE430697 Retiree/AE430700

<table>
<thead>
<tr>
<th>Group number</th>
<th>Class code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>800</td>
</tr>
</tbody>
</table>

PERSONAL INFORMATION

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>Middle initial</th>
<th>Sex</th>
<th>Home phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Birth date

(M M / D D / Y Y Y Y)

Permanent residence street address (PO Box is not allowed)

City

State

ZIP code

County

Mailing address (only if different from your permanent residence address)

Email address (optional)

Emergency contact name (optional)

Relationship to you

Phone number

Cell phone number

Medicare information

Use your Medicare card to complete this section.

- Fill in these blanks so they match your red, white and blue Medicare card.
- or -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.
You must have Medicare Part A and Part B to join a Medicare Advantage plan.

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medicare claim number: ______ - ______ - ______

Is entitled to:

HOSPITAL (Part A)

MEDICAL (Part B)

Effective date: (MM/YY)

Health plan selection: Check the box next to the type of plan you want to enroll in. Then write the name of the specific plan on the line provided. (This information may be pre-filled). For more plan details, look at the benefit summary included in your enrollment kit. Make sure to read the important health plan disclosures on Page 4.

- [ ] Aetna Medicare HMO (write plan name below)
- [ ] Aetna Medicare PPO (write plan name below)
- [ ] Aetna Medicare HMO with Rx (write plan name below)
- [ ] Aetna Medicare PPO with Rx (write plan name below)
- [ ] Medicare P01 ESA PPO w/ Rx 11S3

Fill out the following:

I’m currently enrolled in a Medicare Advantage plan issued by (insurance company name).

I’d like to change to an Aetna plan. I understand this plan may have different health benefits and monthly payments than my current plan.

Select providers: A primary care physician (PCP) is required for HMO plans and is recommended for PPO plans. (PPO members may pay less by choosing a PCP.) If you choose an HMO plan with DMO dental benefits, you must also choose a dentist. To select a PCP or dentist, look at the Aetna Medicare provider directory or call the phone number on the instruction page.

PCP first and last name

PCP office ID

Dentist first and last name

Dentist office ID

(for HMO plans with DMO dental benefits)

Dentist office ID

(for HMO plans with DMO dental benefits)

Make a copy for yourself and return the original

GR-68361 (8-16) 2017
MEDICARE-RELATED QUESTIONS

☐ Yes  ☐ No  Are you an Aetna member?  If Yes, provide your member ID number ________________________________

☐ Yes  ☐ No  Are you the retiree?  If Yes, provide retirement date (MM/DD/YYYY): __ __ / __ __ / __ __

☐ Yes  ☐ No  Are you covering a spouse or dependents under this employer, trust or union plan?

☐ Yes  ☐ No  Do you or your spouse work?

☐ Yes  ☐ No  Do you have end-stage renal disease (ESRD)?  If you’ve had a successful kidney transplant and/or you don’t need regular dialysis any more, attach a note or records from your doctor showing you’ve had a successful kidney transplant or you don’t need dialysis. Otherwise, we may need to contact you to obtain additional information.

☐ Yes  ☐ No  Did you become eligible for Medicare because of ESRD and has it been less than 30 months since you became eligible?  If so, Medicare Advantage Coverage will be your secondary coverage for the first 30 months of the coordination period.

☐ Yes  ☐ No  Was your previous policy terminated?  If Yes, provide termination date: __ __ / __ __ / __ __

☐ Yes  ☐ No  Are you a resident in a long-term care facility, such as a nursing home?

☐ Yes  ☐ No  Are you enrolled in your state Medicaid program?  If Yes, provide your Medicaid number: ________________________________

Please choose your preferred language:
☐ Spanish    ☐ Other ________________________________

Please contact us at the number below if you need information in another language or format (e.g., large print or braille).

This information is available for free in other languages. Please call our customer service number at 1-888-267-2637 (TTY: 711). We’re here 8 a.m. to 6 p.m., local time, Monday through Friday.

Other Rx coverage: Complete only if you have other prescription drug coverage.

☐ Yes  ☐ No  Some individuals may have other drug coverage, including other private insurance, workers’ compensation, VA benefits or through state pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to the Aetna Medicare Advantage Rx plan?  If Yes, please list your other coverage and identification number(s) for this coverage:

Name of other coverage: ________________________________ Phone number: ( )

Address: ________________________________ State:  __________ ZIP:  __________

☐ Yes  ☐ No  Have you had creditable coverage since you became eligible for Medicare prescription drug coverage?

If so, from date (MM/DD/YY) ________________________________ to date (MM/DD/YY) ________________________________

Creditable coverage is prescription drug coverage that is at least as good as Medicare prescription drug coverage.

NOTE:  If you’ve not had creditable coverage, you may have to pay a late enrollment penalty. Aetna may ask you to provide evidence of creditable coverage. If you have questions about the late enrollment penalty, call Aetna at the number provided on this form.
By completing this enrollment application, I agree to the following: Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. I will need to keep my Medicare Parts A and B coverage. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. If I’m enrolling in a Medicare Advantage plan without prescription drug coverage (medical benefits only), I understand that if I don’t have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare’s), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available or under certain special circumstances. The Aetna Medicare Advantage plan serves a specific service area. If I move out of the area that Aetna Medicare Advantage plan serves, I need to notify the plan and my former employer/union/trust so I can disenroll and find a new plan in my new area. Once I’m a member of the Aetna Medicare Advantage plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Aetna when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren’t usually covered under Medicare while out of the country except for limited coverage near the U.S. border. I may also be disenrolled if I do not pay any applicable plan premiums within the grace period. The effective date of disenrollment is in accordance with federal requirements. HMO plans - I understand that beginning on the date Aetna Medicare Advantage plan coverage begins, I must get all my health care from the Aetna Medicare Advantage plan, except for emergency or urgently needed services or out of area dialysis services. Services authorized by the Aetna Medicare Advantage plan and other services contained in my Aetna Medicare Advantage plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR THE AETNA MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES. PPO plans: I understand that beginning on the date Aetna Medicare Advantage plan coverage begins, using services in network can cost less than using services out of network, except for emergency or urgently needed services or out of area dialysis services. I understand I can go to doctors, specialists or hospitals in or out of network. I understand providers must be licensed and eligible to receive payment under the federal Medicare program and agree to accept the PPO plan. I also understand I may have to pay more for services I receive out of network. Services authorized by the Aetna Medicare Advantage plan and other services contained in my Aetna Medicare Advantage plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization when required by the plan, NEITHER MEDICARE NOR THE AETNA MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES. I've been advised not to cancel or drop any supplemental insurance I currently have until I receive written notification of my confirmed effective date from Aetna. I understand the providers in the Aetna network are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. I understand if I'm getting assistance from a sales agent, broker, or other individual employed by or contracted with Aetna’s Medicare Advantage plans, he/she may be paid based on my enrollment in the Aetna Medicare Advantage plan. Release of information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Aetna Medicare will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature: __________________________
Today’s date: ________________________

If you’re the authorized representative, you must sign above and provide the following information:
Representative’s name: ____________________________
Address: ____________________________
Phone number: ____________________________
Relationship to enrollee: ____________________________

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, provider network, premium and/or co-payments/co-insurance may change on January 1 of each year. You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable. This information is available for free in other languages. Please call our customer service number at 1-888-267-2637 (TTY: 711), 8 a.m. to 6 p.m., local time, Monday through Friday.

Esta información está disponible en otros idiomas de manera gratuita. Comuníquese con Servicios al Cliente al 1-888-267-2637 (TTY: 711). Horario de atención: de 8 a.m. a 6 p.m., hora local, de lunes a viernes.

本資訊也有其他語言的免費版本可供選擇。請致電1-888-267-2637與我們的客戶服務部聯絡以瞭解更多資訊。（聽障人士請致電711）辦公時間為週一至週五、當地時間上午 8 時至傍晚 6 時。

Make a copy for yourself and return the original GR-68361 (8-16) 2017
Important HAP Senior Plus (hmo) Information

HAP Senior Plus is only available to individuals with Medicare Parts A and B. To enroll in HAP Senior Plus, each Medicare-eligible person must complete their own individual application. Please return completed HAP Senior Plus applications to the WSU Benefits & Wellness Department for processing.

Please note that although most HAP HMO participating providers accept HAP Senior Plus, some providers do not participate with HAP Senior Plus. Please be sure to choose a participating personal care physician. If your current physician does not participate, please contact Client Services at toll-free (800) 801-1770 and HAP will contact the physician to see if he/she would like to participate.

Disenrollment from HAP Senior Plus can be done at any time during the year. The termination form in the Wayne State University Retiree Handbook must be filled out, signed, and returned to Wayne State University to complete the disenrollment process.

HAP Senior Plus has emergency room and urgent care coverage worldwide. A call to HAP Senior Plus is recommended within 48 hours if admitted into a hospital so your personal care physician can coordinate your care.

If you have any questions regarding HAP Senior Plus, please call the Client Services Department’s toll-free number:

**Toll-Free (800) 801-1770**

Our normal business hours are:

- April 1 through September 30: 8 a.m. to 8 p.m., Monday through Friday
- October 1 through February 14: 8 a.m. to 8 p.m., Seven days a week
- February 15 through March 31: 8 a.m. to 8 p.m., Monday through Friday; 8 a.m. to noon on Saturday

Customer Services also has free language interpreter services available for non-English speakers.

TTY/TDD members can call us at **711**.

Or visit us at [www.hap.org](http://www.hap.org)

Outside of those business hours, you may access our Interactive Voice Recording system at the same number and leave your name and phone number. A HAP Medicare Customer Service Representative will return your phone call the next business day.

HAP Senior Plus (hmo) is a health plan with a Medicare contract. Enrollment in the plan depends on contract renewal.
To Enroll in HAP Senior Plus (hmo), Please Provide the Following Information. Each Medicare beneficiary must complete a separate Enrollment Request Form.

<table>
<thead>
<tr>
<th>Employer or Union Name:</th>
<th>Group #</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAST Name:</td>
<td>FIRST Name:</td>
</tr>
<tr>
<td>Birth Date:</td>
<td>Sex: ☐ M ☐ F</td>
</tr>
<tr>
<td>(<em><strong>/</strong></em>/____)</td>
<td>(____)</td>
</tr>
<tr>
<td>M M / D D / Y Y Y Y</td>
<td></td>
</tr>
</tbody>
</table>

Permanent Residence Street Address (P.O. Box is not allowed):

City: __________________________ State: _______ ZIP Code: _______

Mailing Address (only if different from your Permanent Residence Address):

Street Address: __________________ City: __________________ State: _______ ZIP Code: _______

Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card - OR -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Please read and answer these important questions:

1. Are you a retiree? ............................................................... ☐ Yes ☐ No
   If Yes,
   a. Retirement Date (month/date/year): ________________________
   b. Are you covering a spouse or dependent under this employer or union plan? ☐ Yes ☐ No
      Name of Spouse (if married) ________________________
      Name of dependents (if any) ________________________

2. Do you or your spouse work anywhere? ............................................................... ☐ Yes ☐ No

Y0076_HMO_753 GROUP APP 10/2012

WHITE COPY - HAP YELLOW COPY - ENROLLEE
3. Are you enrolled in your State Medicaid program? ........................................... □ Yes □ No  
   If Yes, please provide your Medicaid number: ________________________________  

4. Do you have End-Stage Renal Disease (ESRD)? ........................................... □ Yes □ No  
   If you have had a successful kidney transplant and/or you don’t need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don’t need dialysis, otherwise we may need to contact you to obtain additional information.  

5. Some individuals may have other drug coverage, including other private insurance, Worker’s Compensation, VA benefits, or State pharmaceutical assistance programs.  
   Will you have other prescription drug coverage in addition to HAP Senior Plus? .............. □ Yes □ No  
   If “yes”, please list your other coverage and your identification (ID) number(s) for this coverage:  
   Name of other coverage: ____________________________________________________________  
   ID # for this coverage: _____________________________________________________________  

6. Are you a resident in a long-term care facility, such as a nursing home? ...................... □ Yes □ No  
   If “yes”, please provide the following information:  
   Name of Institution: _______________________________________________________________  
   Address & Phone Number of Institution (number and street): ______________________________  

Please indicate your choice for Primary Care Physician (PCP), clinic or medical center.  

_________________________  
Primary Care Physician ID #: ________________________________________________________  

Please check one of the boxes below if you would prefer us to send you information in another format:  
□ Large print  
□ Audio tape  

Please contact HAP Senior Plus at (800) 801-1770, if you need information in another format than what is listed above. Our office hours are Monday through Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to noon. TTY/TDD users should call (800) 649-3777.  

Please Read and Sign Below  

By completing this enrollment application, I agree to the following:  

HAP Senior Plus is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don’t have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare’s), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Open Enrollment Period from October 15 – December 7), or under certain special circumstances.  

HAP Senior Plus serves a specific service area. If I move out of the area that HAP Senior Plus serves, I need to notify my employer or union group so I can disenroll and find a new plan in my new area. Once I am a member
of HAP Senior Plus, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from HAP Senior Plus when I get it, to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren’t usually covered under Original Medicare while out of the country except for limited coverage near the U.S. border. Further, I understand that I will be covered for care based on my HAP Senior Plus member contract.

I understand that beginning on the date HAP Senior Plus coverage begins, I must get all of my health care from HAP Senior Plus, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by HAP Senior Plus and other services contained in my HAP Senior Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR HAP SENIOR PLUS WILL PAY FOR THE SERVICES.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with HAP Senior Plus, he/she may be paid based on my enrollment in HAP Senior Plus.

**Release of Information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that HAP Senior Plus will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

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Please keep the yellow copy of your signed form for your personal records.

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Today’s Date:</th>
</tr>
</thead>
</table>

If you are the authorized representative, you must sign above and provide the following information:

**Name:**

<table>
<thead>
<tr>
<th>Address:</th>
</tr>
</thead>
</table>

| Phone Number: (_______) _____ - ________ |

<table>
<thead>
<tr>
<th>Relationship to Enrollee:</th>
</tr>
</thead>
</table>

**Office Use Only:**

**Name of staff member/agent/broker (if assisted in enrollment):**

<table>
<thead>
<tr>
<th>Plan ID #:</th>
</tr>
</thead>
</table>

| Effective Date of Coverage: |

| ICEP: ______ IEP: ______ AEP: ______ SEP (type): ______ Not Eligible: ______ |
To Enroll in HAP Senior Plus (hmo), Please Provide the Following Information.
Each Medicare beneficiary must complete a separate Enrollment Request Form.

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<td></td>
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Permanent Residence Street Address (P.O. Box is not allowed):
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City: ___________________________ State: _______ ZIP Code: _______

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Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card
- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

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<th>Name: ___________________________</th>
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<tbody>
<tr>
<td>MEDICARE CLAIM NUMBER: _______</td>
</tr>
<tr>
<td>Sex: _______</td>
</tr>
<tr>
<td>Is Entitled To: Hospital (Part A) _______</td>
</tr>
<tr>
<td>Medical (Part B) _______</td>
</tr>
<tr>
<td>Effective Date: _______</td>
</tr>
</tbody>
</table>

Please read and answer these important questions:

1. Are you a retiree? ................................................................. □ Yes □ No

   If Yes,
   a. Retirement Date (month/date/year): ___________________________

   b. Are you covering a spouse or dependent under this employer or union plan? □ Yes □ No

      Name of Spouse (if married) ___________________________

      Name of dependents (if any) ___________________________

2. Do you or your spouse work anywhere? ................................................................. □ Yes □ No

Y0076_HMO 753 GROUP APP 10/2012
3. Are you enrolled in your State Medicaid program? ........................................... □ Yes □ No
   If Yes, please provide your Medicaid number: _____________________________

4. Do you have End-Stage Renal Disease (ESRD)? ........................................... □ Yes □ No
   If you have had a successful kidney transplant and/or you don’t need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don’t need dialysis, otherwise we may need to contact you to obtain additional information.

5. Some individuals may have other drug coverage, including other private insurance, Worker’s Compensation, VA benefits, or State pharmaceutical assistance programs.
   Will you have other prescription drug coverage in addition to HAP Senior Plus? ........... □ Yes □ No
   If “yes”, please list your other coverage and your identification (ID) number(s) for this coverage:
   Name of other coverage: _______________________________________________________
   ID # for this coverage: _______________________________________________________

6. Are you a resident in a long-term care facility, such as a nursing home? ..................... □ Yes □ No
   If “yes”, please provide the following information:
   Name of Institution: ___________________________________________________________
   Address & Phone Number of Institution (number and street): ________________________

Please indicate your choice for Primary Care Physician (PCP), clinic or medical center.

_______________________________________________________________
Primary Care Physician ID #: ____________________________________

Please check one of the boxes below if you would prefer us to send you information in another format:

□ Large print
□ Audio tape

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HAP Senior Plus serves a specific service area. If I move out of the area that HAP Senior Plus serves, I need to notify my employer or union group so I can disenroll and find a new plan in my new area. Once I am a member
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I understand that beginning on the date HAP Senior Plus coverage begins, I must get all of my health care from HAP Senior Plus, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by HAP Senior Plus and other services contained in my HAP Senior Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR HAP SENIOR PLUS WILL PAY FOR THE SERVICES.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with HAP Senior Plus, he/she may be paid based on my enrollment in HAP Senior Plus.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that HAP Senior Plus will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Please keep the yellow copy of your signed form for your personal records.

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<th>Signature:</th>
<th>Today’s Date:</th>
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</thead>
</table>

If you are the authorized representative, you must sign above and provide the following information:

Name:

Address:

Phone Number: (_______) _______ - _________

Relationship to Enrollee:

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment):

Plan ID #:___________________________________

Effective Date of Coverage: _________________________

ICEP: _____ IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____
Disabled Dependent Application and Certification

Retiree Information

Name (Last, First, Middle)  Daytime Phone  Social Security Number  Customer ID

Disabled Dependent Child Information

Name of Child (Last, First, Middle)  Sex  Social Security Number

Address (Street, City, County, State, Zip)

Date of Birth  Relationship  Type of Disability  Is dependent receiving Supplemental Security Income (SSI) or Social Security Disability benefits?

1. I understand under Michigan Public Act 275 of 1966, I may enroll my dependent for coverage as a dependent child who is incapable of self-sustaining employment because of a physical or mental disability which occurred before she/he attained the age of 19. I have supplied certification of this disability from a physician licensed in Michigan by having the physician complete this form.

2. I understand my disabled child must be unmarried, legally reside with me, and depend on me for support and maintenance to qualify under Public Act 275. I have supplied certification of this dependency by attaching a copy of my last federal tax return.

3. I agree to furnish proof of my dependent’s continued eligibility whenever required by my insurance carrier or Wayne State University.

4. I understand coverage begins on the effective date determined by Wayne State University.

5. I understand I must notify the Benefits & Wellness Department of changes in my status and that of my family members which may affect coverage.

6. I understand when the insurance carrier accepts my application, I and my family are bound by all conditions of my medical insurance carrier.

7. I authorize my medical insurance carrier to obtain from providers of service, any and all records and information relating to me and my family members.

I am applying for coverage for the above named dependent. I understand and agree to the terms and conditions.

I authorize the release of the information listed above to the insurance plan I have selected for the purpose of obtaining coverage. The information will be provided to the insurance plan in electronic format.

Signature  Date

Physician’s Certification

Type of Disability  Diagnosis

Date First Diagnosed  Prognosis for improvement so as to enable self sustaining employment

Today’s Date

Physician’s Signature  Physician’s Address and Phone

www.wayne.edu/hr/tcw  2017 Plan Year
# Application for Sponsored Dependent Rider

Not available if your medical insurance coverage is Blue Cross Blue Shield.

## Retiree Information

<table>
<thead>
<tr>
<th>Name (Last, First, Middle)</th>
<th>Daytime Phone</th>
<th>Social Security Number</th>
</tr>
</thead>
</table>

## Sponsored Dependent Information

<table>
<thead>
<tr>
<th>Name of (Last, First, Middle)</th>
<th>Sex</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Street, City, County, State, Zip)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Relationship</td>
<td></td>
</tr>
</tbody>
</table>

## If Sponsored Dependent has other insurance coverage, please complete:

<table>
<thead>
<tr>
<th>Name of Individual and Employer, Insuring Dependent</th>
<th>Name and Address of Plan</th>
<th>Group Number</th>
</tr>
</thead>
</table>

I certify the individual I have named above as a sponsored dependent:

1. Is dependent on me for support and is listed as a dependent on my most recent tax return. I have attached a copy of the tax form.
2. Is related to me by blood or marriage.
3. Resides in my home.
4. Is not eligible for Medicare.

The information listed above is correct. I understand I am responsible for payment of the medical insurance premiums based on current rates and any future rate increases.

I authorize the release of the information listed above to the insurance plan I have selected for the purpose of obtaining coverage. The information will be provided to the insurance plan in electronic format.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
Application for Senior Dependent Rider

Not available if your medical insurance coverage is Blue Cross Blue Shield.

Retiree Information

<table>
<thead>
<tr>
<th>Name (Last, First, Middle)</th>
<th>Daytime Phone</th>
<th>Social Security Number</th>
</tr>
</thead>
</table>

Senior Dependent Information

<table>
<thead>
<tr>
<th>Name of (Last, First, Middle)</th>
<th>Sex</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Street, City, County, State, Zip)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Relationship</td>
<td></td>
</tr>
</tbody>
</table>

Senior Dependent Medicare Information

<table>
<thead>
<tr>
<th>Medicare Number</th>
<th>Date Hospital Insurance Effective (Part A)</th>
<th>Date Hospital Insurance Effective (Part B)</th>
</tr>
</thead>
</table>

I certify the individual I have named above as a senior dependent:

1. Is dependent on me for support and is listed as a dependent on my most recent tax return. I have attached a copy of the tax form.
2. Is related to me by blood or marriage.
3. Resides in my home.
4. Is enrolled in Medicare.

The information listed above is correct. I understand I am responsible for payment of the medical insurance premiums based on current rates and any future rate increases.

Signature

Date

I authorize the release of the information listed above to the insurance plan I have selected for the purpose of obtaining coverage. The information will be provided to the insurance plan in electronic format.
Wayne State University continually examines new benefit programs that can be made available to retirees and long-term disability recipients. We are pleased to continue offering Dental Insurance and Vision Insurance through Wayne State University at competitive group rates.

**Dental Coverage Offered through Delta Dental PPO (Point-of-Service)**

**Group # 0005989-0001**

- By enrolling, you will be covered under the Delta Dental PPO (Point-of-Service) plan. This comprehensive program gives you access to two of the nation’s largest dental networks – Delta Dental PPO network (with more than 107,000 unique dentists practicing in more than 293,000 locations) and Delta Premier network (with more than 158,000 unique dentists practicing in more than 368,000 locations).
- When you enroll, you will be required to remain enrolled for one year. You must be enrolled in order to enroll your dependents. If you or your dependents drop this coverage, you will have to wait until the first open enrollment following 12 months to re-enroll.
- If a retiree or dependent drops coverage prior to being covered for at least one full year, he or she must remit all back premiums for the first full year prior to re-enrolling.
- Please review the Dental Plan Summary and Enrollment Form that follow this page for plan features and monthly rates. Questions? Please contact Delta Dental’s Customer Service Department at 1-800-524-0149.
- Delta does not send out identification cards. To confirm enrollment, please call Delta Dental’s Customer Service Department after January 1.

**Vision Insurance Offered through EyeMed Vision Care (Group # 9730946)**

- The retiree program has the same rates and coverage as the active employee Voluntary vision option program.
- Once you elect EyeMed for coverage, you cannot cancel for a 12-month period based on your enrollment date.
- Please review the Vision Plan Summary and Enrollment Form that follow this page for plan features and monthly rates. For information on providers, please contact EyeMed at 1-866-939-3633.

These programs are voluntary. Retirees that choose to enroll may elect either the vision or dental plans, or both plans. You are responsible for the monthly premium costs and will be billed by the university’s billing agent, Automated Benefits Services (ABS).
Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 5989-0001
Wayne State University-Retiree Pay All Plan

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

<table>
<thead>
<tr>
<th>Diagnosis &amp; Preventive Services – exams, cleanings, and fluoride</th>
<th>Delta Dental</th>
<th>Delta Dental</th>
<th>Nonparticipating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Pays</td>
<td>100%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Brush Biopsy – to detect oral cancer</td>
<td>100%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Bitewing Radiographs – bitewing X-rays</td>
<td>100%</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Basic Services – Space Maintainers – appliances to prevent tooth movement</th>
<th>60%</th>
<th>50%</th>
<th>50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Palliative Treatment – to temporarily relieve pain</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>All Other Radiographs – other X-rays</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Minor Restorative Services – fillings and crown repair</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Endodontic Services – root canals</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Periodontic Services – to treat gum disease</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Oral Surgery Services – extractions and dental surgery</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Other Basic Services – misc. services</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Relines and Repairs – to bridges, implants, and dentures</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

| Major Services – crowns                                       | 40% | 30% | 30% |
| Prosthodontic Services – bridges, implants, and dentures       | 40% | 30% | 30% |

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental’s Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable once per calendar year for people up to age 14.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Crowns, onlays and substructures are payable once per tooth in any seven-year period.
- Composite resin (white) restorations are optional treatment on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
• Full and partial dentures are payable once in any seven-year period.
• Bridges and substructures are payable once in any seven-year period.
• Implants and implant related services are payable once per tooth in any seven-year period.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

**Maximum Payment** – $1,200 per person total per Benefit Year on all services.

**Deductible** – $50 Deductible per person total per Benefit Year. The Deductible does not apply to oral exams, prophylaxes (cleanings), fluoride, brush biopsy, and bitewing X-rays.

**Waiting Period** – Not applicable.

**Eligible People** – All Retirees who are eligible for the dental benefits plan and pay the full cost to Wayne State University. The Subscriber pays the full cost of this plan.

Also eligible are your legal spouse and your children to the end of the month in which they turn 26, including your children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled. Where two legally married Subscribers or Retirees are both eligible for coverage under this contract, they may be enrolled together on one application card or separately on individual application cards, but not both. Dependent children may only be enrolled on one application card. Delta Dental will not coordinate benefits for married Subscribers or Retirees who are both eligible under this contract.

A Retiree must be enrolled in order to enroll his or her dependents. If a Retiree or dependent drops coverage at any time, he or she may not re-enroll until the first open enrollment following 12 months.

If a Retiree or dependent drops coverage prior to being covered for at least one full year, he or she must remit all back premiums for the first full year prior to re-enrolling.
## Retiree & LTD Recipient Dental Plan
### Enrollment Form

**RETIREE/LTD RECIPIENT INFORMATION**

<table>
<thead>
<tr>
<th>Add</th>
<th>Term</th>
<th>Change</th>
<th>Last Name (Retiree/LTD Recipient)</th>
<th>First Name</th>
<th>M.I.</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Home Street Address | City/State/Zip | Home Phone | Social Security Number | E-mail Address (If Applicable) |
|--------------------|---------------|------------|------------------------|-------------------------------|

<table>
<thead>
<tr>
<th>A</th>
<th>T</th>
<th>M</th>
<th>F</th>
<th>Last Name (spouse)</th>
<th>First Name</th>
<th>M.I.</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A</th>
<th>T</th>
<th>M</th>
<th>F</th>
<th>Last Name (dependent)</th>
<th>First Name</th>
<th>M.I.</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A</th>
<th>T</th>
<th>M</th>
<th>F</th>
<th>Last Name (dependent)</th>
<th>First Name</th>
<th>M.I.</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
<th>Relationship</th>
</tr>
</thead>
</table>

### Instructions:

Please complete this form and return to the Benefits & Wellness Department at the following address:

Benefits & Wellness
5700 Cass Avenue
3638 Academic / Administration Building
Detroit, MI 48202

Information on the Retiree Dental Program can be accessed on the Human Resources website at [www.hr.wayne.edu/tcw](http://www.hr.wayne.edu/tcw)

### 2017 Dental Plan Rates

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$37.80</td>
<td>per month</td>
</tr>
<tr>
<td>Two-person</td>
<td>$73.12</td>
<td>per month</td>
</tr>
<tr>
<td>Family</td>
<td>$121.61</td>
<td>per month</td>
</tr>
</tbody>
</table>

---

**Signature:** ______________________  **Date:** ______________________

*I hereby certify that the above named dependent(s) meet the eligibility requirements of Wayne State University policy. Once I elect Delta Dental coverage, I understand I cannot cancel for a 12 month period based upon my enrollment date. I understand that my dental contract will be renewed annually and the rates for this plan will be negotiated between Wayne State University and Delta Dental. I understand that my coverage will be renewed automatically each year. I understand that if I or my dependents drop this coverage, I will have to wait until the first open enrollment following 12 months to re-enroll.*

---

Please return to: Benefits & Wellness, 5700 Cass Ave., Suite 3638, Detroit, MI 48202; Fax: 313-577-0637

[www.wayne.edu/hr/tcw](http://www.wayne.edu/hr/tcw)

Form generated: 02/19/2008, Modified 4/16/2009

2017 Plan Year
Vision Wellness for All

With EyeMed Vision Care, you’ll get more than a standard vision benefit. EyeMed’s vision program complements your entire health and wellness package by giving you affordable eye care with the convenience you deserve.

Eye Health Equals Better Health
Regular eye exams do more than just measure your eye sight. They can detect serious eye diseases early, allowing for more proactive treatment. What most people don’t realize is that eye examinations can also reveal the early signs of serious illnesses like diabetes, heart disease and high blood pressure.

Savings All Year Long
EyeMed’s program includes discounts on all your eyewear purchases, even after you’ve used your primary benefit. Whether buying additional pairs of glasses or just stocking up on supplies like cleaning cloths, you never have to pay full price for vision care needs.

Convenience That Counts
As an EyeMed member, you get the convenience your lifestyle demands. You can use your benefits at thousands of private practice and retail-affiliated providers across the country, most with evening or weekend appointments available. And with the nation’s top optical retail brands included in EyeMed’s network, you’ll find high quality eye care where you live, work and shop. We back this up with a Customer Care Center available seven days a week to respond to your questions.

To learn more or to locate a provider near you visit www.eyemedvisioncare.com
Vision Insurance – Retirees, Surviving Spouses and LTD Recipients

Wayne State University has selected EyeMed as your vision wellness program. This plan allows you to improve your health through a comprehensive eye exam, while saving you money on your eye care purchases. The plan is available through thousands of provider locations participating on the EyeMed SELECT network. To see a list of participating providers near you, go to www.eyemedvisioncare.com and choose the SELECT network from the provider locator dropdown box. You can also call the EyeMed Customer Care Center and request a list of providers at 1-866-299-1358 if you are not currently enrolled in vision benefits. Current EyeMed members can call 1-866-723-0514.

<table>
<thead>
<tr>
<th>Vision Care Services</th>
<th>Basic Plan</th>
<th>Enhanced Buy-Up Plan</th>
<th>Out-of-Network Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Member Cost</td>
<td>Member Cost</td>
<td></td>
</tr>
<tr>
<td><strong>Exam with dilation as necessary</strong></td>
<td>$10 Copay</td>
<td>$10 Copay</td>
<td>Up to $35</td>
</tr>
<tr>
<td><strong>Retinal Imaging Benefits</strong></td>
<td>Up to $39</td>
<td>Up to $39</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Contact Lens Fit and Follow-up:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard</td>
<td>Up to $40</td>
<td>$0 copay, paid-in-full fit and two-follow up visits</td>
<td>N/A / $40</td>
</tr>
<tr>
<td>Premium</td>
<td>10% off retail</td>
<td>$0 copay, 10% retail price, then apply $40 allowance</td>
<td>N/A / $40</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td>$0 Copay, $115 Allowance; 20% off balance over $115</td>
<td>$0 Copay, $150 Allowance; 20% off balance over $150</td>
<td>Up to $45</td>
</tr>
<tr>
<td><strong>Standard Plastic Lenses:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>$10 Copay</td>
<td>$10 Copay</td>
<td>Up to $25</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$10 Copay</td>
<td>$10 Copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$10 Copay</td>
<td>$10 Copay</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Lenticular</td>
<td>$10 Copay</td>
<td>$10 Copay</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Standard Progressive</td>
<td>$55 Copay</td>
<td>$10 Copay</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Premium Progressive</td>
<td>$55 Copay, 80% of charge less $120 allowance</td>
<td>$10 Copay, 80% of charge less $120 allowance</td>
<td>Up to $55</td>
</tr>
<tr>
<td><strong>Lens Options</strong> (paid by the member and added to the base price of the lens):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UV Treatment</td>
<td>$15 Copay</td>
<td>$0 Copay</td>
<td>N/A / $5</td>
</tr>
<tr>
<td>Tint (Solid and Gradient)</td>
<td>$15 Copay</td>
<td>$0 Copay</td>
<td>N/A / $5</td>
</tr>
<tr>
<td>Standard Plastic Scratch Coating</td>
<td>$0 Copay</td>
<td>$0 Copay</td>
<td>Up to $5</td>
</tr>
<tr>
<td>Standard Polycarbonate-Adults</td>
<td>$35 Copay</td>
<td>$0 Copay</td>
<td>Up to $5</td>
</tr>
<tr>
<td>Standard Polycarbonate- Kids under 19</td>
<td>$35 Copay</td>
<td>$0 Copay</td>
<td>Up to $5</td>
</tr>
<tr>
<td>Standard Anti-Reflective Coating</td>
<td>$45 Copay</td>
<td>$0 Copay</td>
<td>N/A / $5</td>
</tr>
<tr>
<td>Polarized</td>
<td>20% off retail price</td>
<td>20% off retail price</td>
<td>N/A</td>
</tr>
<tr>
<td>Other Add-Ons and Services</td>
<td>20% off retail price</td>
<td>20% off retail price</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Contact Lenses</strong> (allowance covers materials only)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conventional</td>
<td>$0 Copay, $115 Allowance; 15% off balance over $115</td>
<td>$0 Copay, $150 Allowance; 15% off balance over $150</td>
<td>Up to $100</td>
</tr>
<tr>
<td>Disposables</td>
<td>$0 Copay, $115 Allowance; 15% off balance over $115</td>
<td>$0 Copay, $150 Allowance; 15% off balance over $150</td>
<td>Up to $100</td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>$0 Copay, Paid in Full</td>
<td>$0 Copay, Paid in Full</td>
<td>N/A</td>
</tr>
<tr>
<td>LASIK and PRK Vision Correction</td>
<td>15% off retail price or 5% off promotional pricing</td>
<td>15% off retail price or 5% off promotional pricing</td>
<td>N/A</td>
</tr>
<tr>
<td>Procedures</td>
<td>40% discount off hearing exams and a low price guarantee on discounted hearing aids</td>
<td>40% discount off hearing exams and a low price guarantee on discounted hearing aids</td>
<td>N/A</td>
</tr>
<tr>
<td>Amplifon Hearing Health Care</td>
<td>40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used</td>
<td>40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used</td>
<td>N/A</td>
</tr>
<tr>
<td>Additional Pairs Benefit</td>
<td>40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used</td>
<td>40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Frequency:**
- Exam: Once every calendar year
- Frames: Once every calendar year
- Standard Plastic Lenses or Contact Lenses: Once every calendar year

For instructions on how to register and access EyeMed information, please visit: https://wayne.edu/hr/tcw/health-welfare/vision-plan.php. www.wayne.edu/hr/tcw
Retirees, Surviving Spouse & LTD Recipients
Vision Plan Enrollment Form

Retiree/LTD Recipient Name (Last, First) Please print

Social Security Number

Access ID

Date of Birth

Street Address

City

State

Zip

Home Phone

Email

Please check one: ☐ Add ☐ Terminate ☐ Change of Name, Address or Phone

Please check one: ☐ Basic Plan ☐ Enhanced Buy-Up Plan

Dependent Information: Please provide requested information for self and each dependent you wish to cover. Only eligible dependents may be enrolled. All information for dependents such as Social Security Number and Date of Birth must be provided. The University reserves the right to request additional documentation to verify eligibility of all dependents. List only eligible dependents that you are enrolling. Dependent eligibility rules are the same as Wayne State University’s medical plan.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Social Security Number (Required)</th>
<th>Sex (M/F)</th>
<th>DOB (M/D/Y)</th>
<th>Relationship</th>
<th>Check Box to Add or Terminate Vision</th>
<th>Office Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

Basic Plan vs. Enhanced Buy-Up Plan Premium Schedule

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Basic Plan– Monthly Costs</th>
<th>Enhanced Buy-Up Plan– Monthly Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Premium</td>
<td>Total Premium</td>
</tr>
<tr>
<td>Single</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12-Month</td>
<td>$8.46</td>
<td>$14.92</td>
</tr>
<tr>
<td>Two Person</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12-Month</td>
<td>$16.02</td>
<td>$28.23</td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12-Month</td>
<td>$23.58</td>
<td>$41.55</td>
</tr>
</tbody>
</table>

I hereby certify that the above named dependent(s) meet the eligibility requirements of Wayne State University policy. **Once I elect EyeMed vision coverage, I understand that I cannot cancel for a 12-month period based upon my enrollment date.** I understand my vision contract will be renewed annually and the rates for this plan will be negotiated between my employer and EyeMed Vision Care. I understand my coverage will be renewed automatically each year. I may only cancel during the open enrollment period.

Employee Signature

Date

Please return to: Benefits & Wellness, 5700 Cass Ave., Suite 3638, Detroit, MI 48202; Fax: 313-577-0637

www.wayne.edu/hr/tcw

2017 Plan Year
Life Insurance
Change of Beneficiary Designation Form

RETIREE INFORMATION
Name

Soc Sec Number

Address

Date of Birth

Gender

☐ Female  ☐ Male

Banner ID

BENEFICIARY DESIGNATION
It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact your benefits administrator or your own legal counsel. If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example “33% to Mary Jones, Mother and 67% to Edith Jones, Wife.” If a Trust is named, please indicate the date the Trust was established.

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Address</th>
<th>Soc Sec Number</th>
<th>Relationship</th>
<th>Date of Birth</th>
<th>%</th>
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Contingent

Signature

Date

Please send original to Benefits & Wellness Department.
What Wayne State computing and network services can a retiree access with a WSU AccessID?

- Your WSU E-mail account (on Wayne Connect), which includes your WSU E-mail address (e.g., xy6789@wayne.edu) and an E-mail Name (e.g., email_name@wayne.edu).
- Mail Forwarding services, if you use another e-mail account more often and would prefer to forward your WSU E-mail to that address. For more information about WSU E-mail services, visit Computing & Information Technology’s (C&IT) Website at http://computing.wayne.edu/email.
- Access to the university’s WSU Pipeline portal (http://academica.wayne.edu) for campus information and some Web-based services.
- Retirees with an active Access ID can obtain information about the WSU-Secure campus wireless network by connecting to http://computing.wayne.edu/wireless. Additionally, the WSU_PUBLIC campus wireless network is available to those without an active Access ID. To obtain information about the university’s wired network connect to http://computing.wayne.edu/wired.
- Listing in the WSU Online Directory, if you desire, your home address and phone number may be listed by updating those listings inside WSU Academica.
- Receiving e-mail messages sent to all people affiliated with WSU. As a retiree, you will continue to receive some e-mail messages sent from Wayne State offices. Please note that WSU Bulk Mail services are automated and integrated with the University’s information systems, so individual e-mail addresses cannot be removed.

What happens to my WSU AccessID after I retire?

After you retire from Wayne State, you can continue to use your WSU AccessID and password to access the WSU computing and network services listed above. You do not need to do anything to continue using your AccessID – your status in Banner as a retiree will automatically change your AccessID account over. **If you are retiring from Skilled Trades** then you must fill out and submit the **WSU Skilled Trades Retiree AccessID Request form** (available online at https://calltracker.wayne.edu/forms/retiree/), at least two weeks prior to retirement. If you do not submit this form, your AccessID will be frozen and kept on record for reactivation later should you return to Wayne State University as an employee or a student.

I don’t have an AccessID. Can I get one?

If you are already retired and would like an AccessID to use the services listed above, contact the C&IT Help Desk by phone at (313) 577-4778 or e-mail to helpdesk@wayne.edu.

Are there any changes to Wayne Connect?

Retirees and people on long-term disability will retain their Wayne Connect account for life, but will need to renew every 2 years. Renewal is scheduled to being in 2017 and you will be notified of the need and method to renew by email prior to any email access being removed. If you have questions about using your Wayne Connect account or other AccessID services, visit the Computing & Information Technology website at computing.wayne.edu or contact the C&IT Help Desk at 313-577-HELP. Non-renewal of the account will result in the deletion of email messages (and files stored in OneDrive), as well as an email forwarding address. Remember that Wayne Connect email is a university-provided asset, and WSU reserves the right to monitor the content and revoke access at any time at WSU’s discretion.
Is there anything else I should do upon retirement?
Upon retiring, employees should remove their personal information stored on university computer systems, and copy it onto a personal storage device and/or non-WSU supplied cloud service.

Where can I get more information?
The best place to go for information about computing and network services at Wayne State is C&IT Website - http://computing.wayne.edu. If you need additional help, contact the C&IT Help Desk by phone at (313) 577-4778 or e-mail to helpdesk@wayne.edu.
Choose HAP and get more from your health plan

As a member, you’ll have access to benefits, programs and services that include:

- **A personal service coordinator** – unlike other health plans, you’ll get a dedicated person to answer questions and help guide you through the first two years of membership
- **HAP Advantage program** – discounts on local gym memberships, Weight Watchers® and other healthy living bonuses
- **Member wellness events** – a wide variety of healthy body and mind topics with engaging presenters
- **Travel assistance and identity theft protection** – trusted global emergency travel assistance and free 24/7 identity theft protection through Assist America
- **iStrive® for Better Health** – A personalized digital wellness manager with free wellness tools and programs, powered by WebMD Health Services

HAP has been a trusted name in health insurance for over 50 years. Join the 675,000 members who put their trust in us every day.

For more information, membership.chooseHAP.org