Retiree, Surviving Spouse and Long-Term Disability Recipient Benefits Handbook
This booklet is intended as a convenient summary of the benefit plans for retirees, surviving spouses, and eligible LTD recipients, and is not meant to be a controlling legal document or contract. This booklet does not cover all provisions, limitations and exclusions. If any questions should arise, the legal plan documents, contracts and insurance policies will govern. Wayne State University reserves the right to amend, modify, or terminate these plans at any time and in any manner.
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Welcome Retirees, Surviving Spouses and Long-Term Disability Recipients

Wayne State University is committed to your overall health and well-being. Our benefits are structured to provide high quality health care and financial protection for you and your family. Take a moment to invest in yourself and review the description of benefits available to you.

The Benefits Resource Directory on the following pages lists who you can contact and for what concern.

Please note: We refer to the benefits in this book as “retiree” medical, dental and vision benefits. Some of these benefits are also offered to surviving spouses and long-term disability recipients.

We urge you to keep this handbook and refer to it when you have questions about your benefits. In addition, this handbook and all benefits forms are located on our website at hr.wayne.edu/tcw.

Please always contact us if you have any questions or concerns about your benefits.

To your health,
Benefits & Wellness

Important Notes

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. For more information and your Creditable Coverage Notice, please see page 38.

Address and Beneficiary Changes

It is important to update your address and life insurance beneficiary information as life changes. Please call the HR Service Center to update your address and/or beneficiary information. Thank you!

Do not send health information or your Social Security number in emails!

Wayne State University – Warrior Strong

Our mission
We will create and advance knowledge, prepare a diverse student body to thrive, and positively impact local and global communities.

Our vision
We will be a pre-eminent, public, urban research university known for academic and research excellence, success across a diverse student body, and meaningful engagement in its urban community.

Our values
While our vision and mission show where we want to go, our values guide us on the way. They cut across organizational boundaries, bind us culturally, and permeate our strategic and tactical initiatives. They are the defining traits of the Wayne State community.

- Collaboration: When we work together, drawing upon various talents and perspectives, we achieve better results.
- Integrity: We keep our word, live up to our commitments and are accountable to ourselves and each other.
- Innovation: We are unafraid to try new things and learn by both failure and success.
- Excellence: We strive for the highest quality outcomes in everything we do.
- Diversity and Inclusion: We value all people and understand that their unique experiences, talents and perspectives make us a stronger organization and better people.
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Do not send health information or your Social Security number in emails!
## Benefits Resource Directory

### Contact Phone (hours) and Address Website, Email and App (download free mobile apps listed below through the App Store or Google Play)

### Wayne State University

For general Human Resources and Benefits & Wellness questions:
- Retiring
- Eligibility to participate in a benefit plan
- Enrolling and changing coverage in a benefit plan
- Changing personal information (including dependent information)
- Coverage costs

HR Service Center
313-577-3000 (Mon – Fri 8:30am – 5pm)
fax: 313-577-0637
5700 Cass Ave, Suite 3638 Detroit, MI 48202
24/7 Employee Self-Service web: hr.wayne.edu/tcw
email: askhr@wayne.edu
app: Wayne State University

### Medical, Dental and Vision

For information about:
- Participating providers
- Covered and non-covered expenses
- ID cards (for Medical and Vision)
- Claims

#### Medical Plans

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<td>web: hap.org</td>
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<td>app: HAP OnTheGo</td>
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<th>Group Number: 1000064-1006</th>
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</thead>
<tbody>
<tr>
<td>800-801-1770 (October 1 – March 31 (Sun – Sat 8am – 8pm) April 1 – September 30 (Mon – Fri 8am – 8pm))</td>
<td>web: hap.org</td>
</tr>
<tr>
<td>app: HAP OnTheGo</td>
<td></td>
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</tbody>
</table>

<table>
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</thead>
<tbody>
<tr>
<td>800-662-6667 (Mon – Fri 8am – 5:30pm)</td>
<td>web: bcbsm.com</td>
</tr>
<tr>
<td>app: BCBSM</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aetna Medicare Plan (PPO)</th>
<th>Group Numbers: Retiree: 430700 LTD: 430697</th>
</tr>
</thead>
<tbody>
<tr>
<td>855-335-1407 (Mon – Fri 8am – 8pm) P.O. Box 14088 Lexington, KY 40512</td>
<td>web: aetnaretireeplans.com</td>
</tr>
<tr>
<td>app: Aetna Health</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Blue Cross Shield of Michigan (BCBS)</th>
<th>Group Number: 007002779-0004</th>
</tr>
</thead>
<tbody>
<tr>
<td>877-354-2583 (Mon – Fri 8am – 5:30pm)</td>
<td>web: bcbsm.com</td>
</tr>
<tr>
<td>app: BCBSM</td>
<td></td>
</tr>
</tbody>
</table>

### Virtual Doctor Visits (visit a board-certified doctor via smartphone or computer 24/7)

<table>
<thead>
<tr>
<th>HAP (HMO) – American Well</th>
<th>844-733-3627 (24/7)</th>
<th>web: hap.amwell.com</th>
</tr>
</thead>
<tbody>
<tr>
<td>email: <a href="mailto:support@amwell.com">support@amwell.com</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>app: HAPMi</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Blue Care Network Blue Cross Blue Shield</th>
<th>844-606-1608 (24/7)</th>
<th>web: bcbsonlinevisits.com</th>
</tr>
</thead>
<tbody>
<tr>
<td>app: BCBSM Online Visits</td>
<td></td>
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</table>

### Home Delivery Pharmacy Service (free shipping, 90-day supply, licensed pharmacists)

<table>
<thead>
<tr>
<th>HAP and HAP Senior Plus – Pharmacy Advantage</th>
<th>800-456-2112 (Mon – Fri 8am – 6pm) After hours available</th>
<th>web: pharmacyadvantagexrs.com</th>
</tr>
</thead>
<tbody>
<tr>
<td>app: HAP OnTheGo</td>
<td></td>
<td></td>
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<tr>
<th>Aetna – CVS Caremark</th>
<th>877-238-6211 (24/7)</th>
<th>web: aetna.com</th>
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<tr>
<td>app: CVS Caremark</td>
<td></td>
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<table>
<thead>
<tr>
<th>Blue Care Network – Express Scripts</th>
<th>800-229-0832 (24/7)</th>
<th>web: express-scripts.com/</th>
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<tbody>
<tr>
<td>app: Express Scripts</td>
<td></td>
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</tbody>
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<tr>
<th>Blue Cross Blue Shield – Express Scripts</th>
<th>800-778-0735 (24/7)</th>
<th>web: express-scripts.com/</th>
</tr>
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<tbody>
<tr>
<td>app: Express Scripts</td>
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</table>

### Dental

<table>
<thead>
<tr>
<th>Delta Dental</th>
<th>Group Number: 0005989-0001</th>
<th>800-482-8915 (Mon – Fri 8am – 8pm)</th>
<th>web: deltadentalmi.com</th>
</tr>
</thead>
<tbody>
<tr>
<td>app: Delta Dental Mobile</td>
<td></td>
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</tbody>
</table>

### Vision

<table>
<thead>
<tr>
<th>EyeMed</th>
<th>Group Number: 9730946</th>
<th>866-939-3633 (every day, 7am – 11pm)</th>
<th>web: eyemed.com</th>
</tr>
</thead>
<tbody>
<tr>
<td>app: EyeMed Members</td>
<td></td>
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</tbody>
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### Monthly Billing and Payments

For information about:
- Aetna – Medical insurance enrollments, terminations and payments
- Arcadia – Retire medical insurance payments (excluding Aetna) and COBRA

<table>
<thead>
<tr>
<th>Aetna</th>
<th>855-335-1407 (Mon – Fri 8am – 8pm) P.O. Box 14088 Lexington, KY 40512</th>
<th>web: aetnaretireeplans.com</th>
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<tr>
<th>Arcadia (acquired by Navia Benefits)</th>
<th>866-329-4333 (Mon – Fri 8am – 4:30pm) fax: 269-381-5844 612 S. Park St. Kalamazoo, MI 49007</th>
<th>web: arcadiabenefits.com</th>
</tr>
</thead>
<tbody>
<tr>
<td>app: Arcadia Health</td>
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# Benefits Resource Directory

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**HR Service Center**
- Phone: 313-577-3000 (Mon – Fri 8:30am – 5pm)
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- Email: askhr@wayne.edu
- Address: 5700 Cass Ave., Suite 3638
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### Medical Plans

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- Group Number: 10000664-1001
- Phone: 800-422-4641 (Mon – Fri 8am – 7pm)
- Website: hap.org
- Email: support@amwell.com
- App: Amwell: Doctor Visits 24/7

#### Health Alliance Plan (HAP) Senior Plus (HMO)
- Group Number: 1000064-1006
- Phone: 800-456-2112 (Sun – Sat 8am – 8pm)
- Website: pharmacyadvantagerx.com
- Email: support@amwell.com
- App: Amwell: Doctor Visits 24/7

#### Blue Care Network (BCN) (HMO)
- Group Number: 00111308-0005
- Phone: 800-662-6667 (Mon – Fri 8am – 5:30pm)
- Website: bcbsm.com
- Email: support@amwell.com
- App: Amwell: Doctor Visits 24/7

#### Blue Cross Blue Shield
- Phone: 844-606-1608 (24/7)
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  - App: Pharmacy Advantage

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  - Website: aetna.com
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  - App: Express Scripts

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  - Website: express-scripts.com
  - Email: support@amwell.com
  - App: Express Scripts

### How to Enroll

- **Website**
- **Email**
- **App**

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Benefits Resource Directory

Medicare and Social Security

For information about:
- Medicare Eligibility
- Enrolling in Medicare
- Medicare Parts A, B & D

Medicare
Helpline: 800-633-4227
Helpline TTY: 877-486-2048
Coordination of Benefits: 855-798-2627
web: medicare.gov

Michigan Medicaid Assistance Program
800-803-7174
web: michigan.gov.mdhhs

Social Security Administration
800-772-1213
TTY: 800-325-0778 (Mon – Fri 7am – 7pm)
web: socialsecurity.gov

Medicare and Social Security

Website, Email and App
(download free mobile apps listed below through the App Store or Google Play)

Contact
Phone (hours) and Address
Medicare and Social Security
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- Enrolling in Medicare
- Medicare Parts A, B & D

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Helpline: 800-633-4227
Helpline TTY: 877-486-2048
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web: medicare.gov

Michigan Medicaid Assistance Program
800-803-7174
web: michigan.gov.mdhhs

Social Security Administration
800-772-1213
TTY: 800-325-0778 (Mon – Fri 7am – 7pm)
web: socialsecurity.gov

Life Insurance, LTD and Retirement Savings Plans

Life Insurance
For:
- Enrollment
- To file death claims
- Coverage questions
- Beneficiary designation

HR Service Center
313-577-3000
(Mon – Fri 8:30am – 5pm)
fax: 313-577-0637
5700 Cass Ave., Suite 3638
Detroit, MI 48202
web: hr.wayne.edu/tcw
email: askhr@wayne.edu
app: Wayne State University

For:
- Questions after a claim has been paid or denied
- Conversion coverage administration
- Portability coverage administration

Sun Life Financial
800-247-6875
(Mon – Fri 8am – 8pm)
One Sun Life Executive Park
Wellesley Hills, MA 02481
web: sunlife.com/us
email: usweb_general_information@sunlife.com
app: Sun Life Benefit Tools

Fidelity Investments
1-on-1 in-person counseling
800-343-0860
(Mon – Fri 8am – 12am)
PO Box 770001
Cincinnati, OH 45277-0018
Overnight Mail
100 Crosby Parkway K1TE
Covington, KY 41015
web: netbenefits.com/wayneuniversity
app: Fidelity Investments

Fidelity Investments
1-on-1 in-person counseling
800-642-7131
(Mon – Fri 8am – 12am)
web: fidelity.com/atwork/reservations

TIAA
800-842-2252
(Mon – Fri 8am – 10pm, Sat 9am – 6pm)
PO Box 1268
Charlotte, NC 28201-1268
Overnight Mail
8500 Andrew Carnegie Blvd
Charlotte, NC 28262
web: tiaa.org/wayne

TIAA 1-on-1 in-person counseling
800-732-8353
(Mon – Fri 8am – 10pm)
web: tiaa.org/wayne

Contact
Phone (hours) and Address
Website, Email and App
(download free mobile apps listed below through the App Store or Google Play)

Long-Term Disability (LTD)
For:
- Claim filing
- Coverage questions

HR Service Center
313-577-3000
(Mon – Fri 8:30am – 5pm)
fax: 313-577-0637
5700 Cass Ave., Suite 3638
Detroit, MI 48202
web: hr.wayne.edu/tcw
email: askhr@wayne.edu

For:
- After filing Claims

CIGNA
800-362-4462
888-842-4462
(Mon – Fri 7am – 5pm)
PO Box 29221
Phoenix, AZ 85038-9221
web: mycigna.com
app: MyCigna

Retirement Savings Plans
For:
- Individual counseling
- What to do with your accounts after retiring

Fidelity Investments
1-on-1 in-person counseling
800-343-0860
(Mon – Fri 8am – 12am)
PO Box 770001
Cincinnati, OH 45277-0018
Overnight Mail
100 Crosby Parkway K1TE
Covington, KY 41015
web: netbenefits.com/wayneuniversity
app: Fidelity Investments

Fidelity Investments
1-on-1 in-person counseling
800-642-7131
(Mon – Fri 8am – 12am)
web: fidelity.com/atwork/reservations

TIAA
800-842-2252
(Mon – Fri 8am – 10pm, Sat 9am – 6pm)
PO Box 1268
Charlotte, NC 28201-1268
Overnight Mail
8500 Andrew Carnegie Blvd
Charlotte, NC 28262
web: tiaa.org/wayne

TIAA 1-on-1 in-person counseling
800-732-8353
(Mon – Fri 8am – 10pm)
web: tiaa.org/wayne
## Benefits Resource Directory

### Medicare and Social Security

**For information about:**
- Medicare Eligibility
- Enrolling in Medicare
- Medicare Parts A, B & D

<table>
<thead>
<tr>
<th>Resource</th>
<th>Contact Information</th>
<th>Website</th>
<th>Email</th>
<th>App</th>
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</thead>
</table>
| Medicare | Helpline: 800-633-4227  
Helpline TTY: 877-486-2048  
Coordination of Benefits: 855-798-2627 | web: medicare.gov | | |
| Michigan Medicaid Assistance Program | 800-803-7174 | web: michigan.gov.mdhhs | | |
| Social Security Administration | 800-772-1213  
TTY: 800-325-0778  
(Mon – Fri 7am – 7pm) | web: socialsecurity.gov | | |

### Life Insurance, LTD and Retirement Savings Plans

#### Life Insurance

**For:**
- Enrollment
- To file death claims
- Coverage questions
- Beneficiary designation

<table>
<thead>
<tr>
<th>Resource</th>
<th>Contact Information</th>
<th>Website</th>
<th>Email</th>
<th>App</th>
</tr>
</thead>
</table>
| HR Service Center | 313-577-3000  
(Mon – Fri 8:30am – 5pm)  
fax: 313-577-0637  
5700 Cass Ave., Suite 3638  
Detroit, MI 48202 | web: hr.wayne.edu/tcw  
email: askhr@wayne.edu  
app: Wayne State University | | |
| Sun Life Financial | 800-247-6875  
(Mon – Fri 8am – 8pm)  
One Sun Life Executive Park  
Wellesley Hills, MA 02481 | web: sunlife.com/us  
email: usweb_general_information@sunlife.com  
app: Sun Life Benefit Tools | | |

#### Long-Term Disability (LTD)

**For:**
- Claim filing
- Coverage questions
- After filing Claims

<table>
<thead>
<tr>
<th>Resource</th>
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<th>Email</th>
<th>App</th>
</tr>
</thead>
</table>
| CIGNA | 800-362-4462  
888-842-4462  
(Mon – Fri 7am – 5pm)  
PO Box 29221  
Phoenix, AZ 85038-9221 | web: mycigna.com  
app: MyCigna | | |

#### Retirement Savings Plans

**For:**
- Individual counseling
- What to do with your accounts after retiring

<table>
<thead>
<tr>
<th>Resource</th>
<th>Contact Information</th>
<th>Website</th>
<th>Email</th>
<th>App</th>
</tr>
</thead>
</table>
| Fidelity Investments | 800-343-0860  
(Mon – Fri 8am – 12am)  
PO Box 770001  
Cincinnati, OH 45277-0018  
Overnight Mail  
100 Crosby Parkway KC1E  
Covington, KY 41015 | web: netbenefits.waynestateuniversity.com  
app: Fidelity Investments | | |
| Fidelity Investments 1-on-1 in-person counseling | 800-642-7131  
(Mon – Fri 8am – 12am) | web: fidelity.com/atwork/reservations | | |
| TIAA | 800-842-2252  
(Mon – Fri 8am – 10pm,  
Sat 9am – 6pm)  
PO Box 1268  
Charlotte, NC 28201-1268  
Overnight Mail  
8500 Andrew Carnegie Blvd  
Charlotte, NC 28262 | web: tiaa.org/wayne  
app: TIAA | | |
| TIAA 1-on-1 in-person counseling | 800-732-8353  
(Mon – Fri 8am – 10pm) | web: tiaa.org/wayne | | |
Benefits Resource Directory

Contact Phone (hours) and Address Website, Email and App (download free mobile apps listed below through the App Store or Google Play)

Additional Retiree Benefits
- Mort Harris Recreation & Fitness Center membership
- Retiree OneCard
- Free Parking
- Continued Email Access
- Senior Citizen Reduced Tuition (75% off tuition for age 60+)
- Voluntary Benefits
- Society of Active Retirees (SOAR)

On-Campus Retiree Benefits
Mort Harris Recreation and Fitness Center
313-577-2348
(Mon – Fri 5:30am – 11pm, Sat – Sun 10am – 7pm)
fax: 313-577-5843
5210 Gullen Mall, Detroit, MI 48202
web: rfc.wayne.edu
email: campusrec@wayne.edu

OneCard/Parking Service Center
313-577-CARD (2273)
(Mon – Fri 8:30am – 5pm)
42 W. Warren Avenue, Suite 257, Detroit, Michigan 48202
web: onecard.wayne.edu
email: onecard@wayne.edu

C&IT Help Desk
313-577-4357
(Mon – Fri 7:30am – 8pm)
Student Center Building, 5221 Gullen Mall, Suite 005, Detroit, MI 48202
web: tech.wayne.edu
email: helpdesk@wayne.edu

Senior Citizen Reduced Tuition
Questions: Student Service Center
313-577-2100
(Mon – Thurs 8:30am – 4:30pm, Fri 8:45am – 4:30pm)
The Welcome Center
42 W. Warren Ave., 1st Floor Lobby
(Mon – Thurs 8:30am – 6:00pm, Fri 8:30am – 5:00pm)
Send documents to:
Records and Registration
5057 Woodward, 5th Floor, Detroit, 48202
Fax: 313-577-7870
web: wayne.edu/registrar/tuition
email: studentservice@wayne.edu

Voluntary Benefits
Liberty Mutual – Home & Auto Insurance
248-699-9917
web: libertymutual.com/wsu
app: Liberty Mutual Mobile

Trustmark – Long-Term Care Insurance
800-918-8877
400 Field Drive, Lake Forest, IL 60045
web: trustmarkinsurancesolutions.com/
email: customercare@trustmarkinsurancesolutions.com

Other
Society of Active Retirees (SOAR)
248-626-0296
(Mon – Thurs 9:30am – 3:00pm, Fri 9:30am – 1:00pm)
c/o Adat Shalom Synagogue
29901 Middlebelt Rd., Farmington Hills, MI 48334
web: soarexplore.com

Retirement Summary
Retirees, the department of Benefits & Wellness would like to thank you for your service, and is here to assist you with your transition into retirement and during retirement.

- Retirement Eligibility: To be considered a retiree from Wayne State University, you must meet the following criteria:
  - You must be age 55 or older, and
  - You must have at least 10 years of service or 5 years or more of university contributions into your 403(b) retirement savings account.
- When retiring:
  - You should send a copy of your Letter of Retirement to your supervisor or department chair and to the HR Service Center at least 2 weeks prior to your date of retirement.
  - Your Letter of Retirement should include your last day of employment and your date of retirement. The two dates should be consecutive. For example, if you listed February 9 as your last day of employment, it would then follow that February 10 is your date of retirement. Your department will process your termination; however, sending the HR Service Center your Letter of Retirement ensures that you’re set up in the system as a retiree and that you’ll receive the benefits associated with retiring (group life insurance, free parking, email continuation, etc.).
  - Contact the HR Service Center to enroll in retiree medical, dental and/or vision insurance, to ensure your life insurance beneficiary(ies) are up to date, and to ensure you take advantage of all the other benefits available to you as a retiree.
- Current retirees:
  - Changes to your WSU benefits can be made during the annual Open Enrollment period each year.
  - Be sure to contact the HR Service Center to keep your address and life insurance beneficiaries updated.
Retirement Summary

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• Current retirees:
  * Changes to your WSU benefits can be made during the annual Open Enrollment period each year.
  * Be sure to contact the HR Service Center to keep your address and life insurance beneficiaries updated.
Surviving Spouse Summary

A surviving spouse is the spouse of a deceased retiree, long-term disability recipient or active employee (who was eligible for retirement as of the date of death). Retiree medical insurance is offered to surviving spouses. Surviving spouses of deceased active employees are eligible for continuation of medical, dental and vision under COBRA (not applicable for 65+) or retiree medical insurance. To be eligible for medical benefits, a surviving spouse must have been on a WSU medical plan as a dependent as of the date of death of the retiree, long-term disability recipient or active employee. Retiree dental and vision insurance is not offered to surviving spouses.

If you are the beneficiary of a WSU life insurance policy, refer to Life Insurance – How to File a Death Claim on page 32.

Long-Term Disability Summary

Eligible long-term disability (LTD) recipients may enroll in subsidized retiree medical insurance. These eligible LTD recipients are also eligible to enroll in the retiree dental and retiree vision plans at full retiree rates. In addition, LTD recipients are eligible for:

- Monthly disability income benefit up to 66 2/3% of your base salary to a max benefit of $7,000 per month (paid by the university's long-term disability insurance carrier).
- If you were participating in the WSU 403(b) retirement savings plan at the start of your disability, the university's long-term disability insurance carrier will continue to contribute up to 15% of your last day of work salary to your retirement account.
- If you were enrolled in Basic and/or Supplemental Life Insurance as of your last day of work prior to your disability, WSU will continue to pay this benefit. Please note that this does not apply to Dependent Life Insurance. The spouse and/or child(ren) have the option of converting the dependent life insurance policy to a direct pay plan with Sun Life.

If you stop receiving the long-term disability insurance benefit for whatever reason, you may qualify to transition to retiree status if you met the criteria to retire as of your last day at work. Retiree benefits would then apply. Contact the HR Service Center if you need to transition to retiree status.

Medical, Dental and Vision Insurance

Eligibility

- Retiree
- Long-term disability recipient
- Surviving spouse
  - Eligible for retiree medical insurance, and
  - Only if they were enrolled as a dependent on the retiree, LTD recipient or active employee’s WSU medical plan as of the date of death.

Dependent Eligibility

Eligible dependents include:

- Legal spouse
- Other Eligible Person (OEP) – If you do not already enroll a spouse for medical, dental or vision insurance benefits, you may enroll one other eligible person (OEP) if you and your OEP meet all the following requirements:
  - An adult, age 26 or older; and
  - Currently resides in the same residence as the employee and has done so for 18 continuous months prior to the individual’s enrollment, other than as a tenant; and
  - Not a dependent of the employee as defined by the IRS; and
  - Not related by blood or marriage.
  - Not a spouse, child, grandchild, parent, grandparent, sibling, niece, nephew, aunt, uncle, cousin, landlord, renter, boarder or tenant of employee.
- Your children or the children of your spouse/OEP, defined as:
  - Children by birth or adoption (or placed in your home for final adoption).
  - Children by legal guardianship.
  - Stepchildren.
  - Under age 26.
- Principally supported children (Blue Cross Blue Shield and Blue Care Network only), defined as:
  - Not your child by birth or marriage until the end of the year in which they reach age 19.
  - Principally supported by you for at least six consecutive months (nine months for BCBS).
  - Related to you by blood or marriage.
  - Claimed as your dependents on your most recent income tax return.
- Unmarried disabled dependent children who:
  - Became disabled before reaching age 26, and are incapable of self-sustaining employment by reason of mental or physical handicap.
  - Have reached the end of the month in which they turned 26.
  - Are dependent on you for support and maintenance.
Surviving Spouse Summary

A surviving spouse is the spouse of a deceased retiree, long-term disability recipient or active employee (who was eligible for retirement as of the date of death). Retiree medical insurance is offered to surviving spouses. Surviving spouses of deceased active employees are eligible for continuation of medical, dental and vision under COBRA (not applicable for 65+) or retiree medical insurance. To be eligible for medical benefits, a surviving spouse must have been on a WSU medical plan as a dependent as of the date of death of the retiree, long-term disability recipient or active employee. Retiree dental and vision insurance is not offered to surviving spouses.

If you are the beneficiary of a WSU life insurance policy, refer to Life Insurance – How to File a Death Claim on page 32.

Long-Term Disability Summary

Eligible long-term disability (LTD) recipients may enroll in subsidized retiree medical insurance. These eligible LTD recipients are also eligible to enroll in the retiree dental and retiree vision plans at full retiree rates. In addition, LTD recipients are eligible for:

- Monthly disability income benefit up to 66 2/3% of your base salary to a max benefit of $7,000 per month (paid by the university's long-term disability insurance carrier).

If you were participating in the WSU 403(b) retirement savings plan at the start of your disability, the university's long-term disability insurance carrier will continue to contribute up to 15% of your last day of work salary to your retirement account.

If you were enrolled in Basic and/or Supplemental Life Insurance as of your last day of work prior to your disability, WSU will continue to pay this benefit. Please note that this does not apply to Dependent Life Insurance. The spouse and/or child(ren) have the option of converting the dependent life insurance policy to a direct pay plan with Sun Life.

If you stop receiving the long-term disability insurance benefit for whatever reason, you may qualify to transition to retiree status if you met the criteria to retire as of your last day at work. Retiree benefits would then apply. Contact the HR Service Center if you need to transition to retiree status.

Medical, Dental and Vision Insurance

Eligibility

- Retiree
- Long-term disability recipient
- Surviving spouse
  - Eligible for retiree medical insurance, and
  - Only if they were enrolled as a dependent on the retiree, LTD recipient or active employee's WSU medical plan as of the date of death.

Dependent Eligibility

Eligible dependents include:

- Legal spouse
- Other Eligible Person (OEP) – If you do not already enroll a spouse for medical, dental or vision insurance benefits, you may enroll one other eligible person (OEP) if you and your OEP meet all the following requirements:
  - An adult, age 26 or older; and
  - Currently resides in the same residence as the employee and has done so for 18 continuous months prior to the individual's enrollment, other than as a tenant; and
  - Not a dependent of the employee as defined by the IRS; and
  - Not related by blood or marriage.
  - Not a spouse, child, grandchild, parent, grandparent, sibling, niece, nephew, aunt, uncle, cousin, landlord, renter, boarder or tenant of employee.

- Your children or the children of your spouse/OEP, defined as:
  - Children by birth or adoption (or placed in your home for final adoption).
  - Stepchildren.
  - Under age 26.

- Principally supported children (Blue Cross Blue Shield and Blue Care Network only), defined as:
  - Not your child by birth or marriage until the end of the year in which they reach age 19.
  - Principally supported by you for at least six consecutive months (nine months for BCBS).
  - Related to you by blood or marriage.
  - Claimed as your dependents on your most recent income tax return.

- Unmarried disabled dependent children who:
  - Became disabled before reaching age 26, and are incapable of self-sustaining employment by reason of mental or physical handicap.
  - Have reached the end of the month in which they turned 26.
  - Are dependent on you for support and maintenance.
• Your sponsored dependent (Blue Care Network only), defined as:
  • An adult, age 26 or older.
  • Dependent on your financial support.
  • Claimed on your most recent income tax return.
  • Resides with you permanently.

Dependent documentation must be submitted as proof of eligibility for any dependents added to the medical, dental or vision insurance plans. Outside of the annual Open Enrollment period, you have 30 days from your date of retirement, LTD eligibility or a change in status to enroll dependents.

Ineligible Dependents
Please review the eligibility requirements described above. Ineligible dependents must be removed from your coverage within 30 days of becoming ineligible, and their last day of coverage will be as of the date they became ineligible (with exception of dependents turning 26 years old, in which coverage ends at the end of the month in which they turn 26). As a reminder, we have included a few examples of ineligible dependents:

• Anyone who is not your legal spouse or qualified other eligible person (OEP), as defined above.
• Dependents no longer covered by a court order.
• Dependent children over age 26 (coverage ends at the end of the month in which they turn 26).
• Parents, grandparents and in-laws.

Enrolling an ineligible dependent or continuing coverage for your dependent who no longer qualifies as an eligible dependent is considered by WSU to be evidence of fraud and intentional misrepresentation of material facts. Proof substantiating dependent eligibility must be provided, when requested, which may include documents asked for during a Dependent Audit by a third-party administrator. Failure to provide the requested documents verifying proof of dependent eligibility in a timely manner may cause termination of your dependent’s coverage, and you generally will not be able to reinstate coverage until the next annual Open Enrollment period.

Costs, Billing & Payments
The cost for medical, dental and vision insurance benefits for yourself and your eligible dependents is based on what benefits you elect, the level of coverage you elect, and, for medical, if you or your dependents are enrolled in Medicare Part A and Part B. All costs can be found here: hr.wayne.edu/tcw/health-welfare/medical-rates.

Billing and payments for medical, dental and vision insurance benefits are handled through WSU’s billing agent, Arcadia (acquired by Navia Benefits).

If you enroll in the Aetna Medicare Plan (PPO), billing and payments are handled directly through Aetna.

It is your responsibility to make your monthly payment on time. Payments are due by the first of the month for the given month’s coverage. You can elect to have automatic withdrawals made from your savings or checking account, or you can make a payment manually each month via the internet or mail. A payment due and not made by the first of the current month may result in coverage being cancelled retroactive to the last day of the month in which a payment was received (re-enrollment may be subject to the next annual Open Enrollment period, if terminated due to nonpayment).

How to Enroll in, Change or Cancel Benefits
You can enroll in, change or cancel medical, dental or vision insurance benefits as a result of:

• Change in status
• Open Enrollment

After your initial eligibility period for benefits, you can enroll or re-enroll only during the annual Open Enrollment period unless you have a change in status during the year.

Please note: All retiree benefits forms can be found in the Retiree, Surviving Spouse and Long-Term Disability Recipient Benefits Enrollment Forms booklet.

Enrollment

• Newly eligible
  • Submit enrollment form(s) and supporting documentation within 30 days

• Change in status
  • Submit enrollment form(s) and supporting documentation within 30 days

• Open Enrollment
  • Submit enrollment form(s) and supporting documentation within the Open Enrollment period for changes to take effect the following January 1

• When COBRA is ending
  • You can enroll into a WSU retiree medical, dental or vision insurance plan if you were covered under COBRA and your COBRA is ending. Only retiree plans are available, which will result in a change of plans for you if you were enrolled in Total Health Care or Community Blue under COBRA. Submit enrollment form(s) and dependent supporting documentation within 30 days of COBRA ending.

You must have been enrolled in an active employee WSU medical, dental or vision plan at the time of retirement, becoming a surviving spouse, or LTD eligibility in order to enroll in a WSU retiree medical, dental or vision plan. Surviving spouses are eligible for medical only.
Your sponsored dependent (Blue Care Network only), defined as:

- An adult, age 26 or older.
- Dependent on your financial support.
- Claimed on your most recent income tax return.
- Resides with you permanently.

Dependent documentation must be submitted as proof of eligibility for any dependents added to the medical, dental or vision insurance plans. Outside of the annual Open Enrollment period, you have 30 days from your date of retirement, LTD eligibility or a change in status to enroll dependents.

Ineligible Dependents

Please review the eligibility requirements described above. Ineligible dependents must be removed from your coverage within 30 days of becoming ineligible, and their last day of coverage will be as of the date they became ineligible (with exception of dependents turning 26 years old, in which coverage ends at the end of the month in which they turn 26). As a reminder, we have included a few examples of ineligible dependents:

- Anyone who is not your legal spouse or qualified other eligible person (OEP), as defined above.
- Dependents no longer covered by a court order.
- Dependent children over age 26 (coverage ends at the end of the month in which they turn 26).
- Parents, grandparents and in-laws.

Enrolling an ineligible dependent or continuing coverage for your dependent who no longer qualifies as an eligible dependent is considered by WSU to be evidence of fraud and intentional misrepresentation of material facts.

Proof substantiating dependent eligibility must be provided, when requested, which may include documents asked for during a Dependent Audit by a third-party administrator. Failure to provide the requested documents verifying proof of dependent eligibility in a timely manner may cause termination of your dependent’s coverage, and you generally will not be able to reinstate coverage until the next annual Open Enrollment period.

Costs, Billing & Payments

The cost for medical, dental and vision insurance benefits for yourself and your eligible dependents is based on what benefits you elect, the level of coverage you elect, and, for medical, if you or your dependents are enrolled in Medicare Part A and Part B. All costs can be found here: hr.wayne.edu/tcw/health-welfare/medical-rates.

Billing and payments for medical, dental and vision insurance benefits are handled through WSU’s billing agent, Arcadia (acquired by Navia Benefits).

If you enroll in the Aetna Medicare Plan (PPO), billing and payments are handled directly through Aetna. It is your responsibility to make your monthly payment on time. Payments are due by the first of the month for the given month’s coverage. You can elect to have automatic withdrawals made from your savings or checking account, or you can make a payment manually each month via the internet or mail. A payment due and not made by the first of the current month may result in coverage being cancelled retroactive to the last day of the month in which a payment was received (re-enrollment may be subject to the next annual Open Enrollment period, if terminated due to nonpayment).

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After your initial eligibility period for benefits, you can enroll or re-enroll only during the annual Open Enrollment period unless you have a change in status during the year.

Please note: All retiree benefits forms can be found in the Retiree, Surviving Spouse and Long-Term Disability Recipient Benefits Enrollment Forms booklet.

Enrollment

- Newly eligible
  - Submit enrollment form(s) and supporting documentation within 30 days
- Change in status
  - Submit enrollment form(s) and supporting documentation within 30 days
- Open Enrollment
  - Submit enrollment form(s) and supporting documentation within the Open Enrollment period for changes to take effect the following January 1
- When COBRA is ending
  - You can enroll into a WSU retiree medical, dental or vision insurance plan if you were covered under COBRA and your COBRA is ending. Only retiree plans are available, which will result in a change of plans for you if you were enrolled in Total Health Care or Community Blue under COBRA. Submit enrollment form(s) and dependent supporting documentation within 30 days of COBRA ending.

You must have been enrolled in an active employee WSU medical, dental or vision plan at the time of retirement, becoming a surviving spouse, or LTD eligibility in order to enroll in a WSU retiree medical, dental or vision plan. Surviving spouses are eligible for medical only.
Enrollment Changes

• Change in status
  • Submit enrollment form(s) and dependent supporting documentation within 30 days

• Open Enrollment
  • Submit enrollment form(s) and dependent supporting documentation within the Open Enrollment period for changes to take effect the following January 1

Other than during each year’s annual Open Enrollment period, you can change your coverage election only if you experience a change in status for which you may be required or allowed to make changes to your coverage. The coverage election must be consistent with your change in status (i.e. you cannot make a coverage change for financial reasons or because a provider stops participating in a network).

Enrolling in a WSU Medicare Advantage Plan (either HAP Senior Plus (HMO) or Aetna Medicare Plan (PPO)) is subject to Medicare special enrollment/annual Open Enrollment guidelines. If you plan to include your spouse as a dependent on your university medical insurance plan and he/she is under age 65, neither HAP Senior Plus (HMO) nor Aetna Medicare Plan (PPO) will be available to you until you are both Medicare eligible. Please visit medicare.gov for information regarding Medicare enrollment.

A change in status may include:

• Your marriage, divorce, legal separation or annulment;
• Death of an eligible dependent;
• Addition of an eligible dependent through birth, adoption or placement for adoption;
• A Qualified Medical Child Support Order that requires you to provide medical coverage for a child; or
• You and/or your eligible dependents become eligible and enroll in or lose eligibility for Medicare or Medicaid.

The date coverage for you and/or your eligible dependents begins or ends depends on the change in status (see Start and End Dates of Coverage on pages 14-15).

Canceling Coverage

• Medical
  • You may cancel medical coverage at any time by submitting the Medical Plan Termination form or a letter of termination. Cancellations cannot be made retroactively. Your coverage will end at the end of the month in which we receive your letter of termination or termination form.
  • To terminate Aetna Medicare Plan (PPO) coverage, you must communicate your intentions directly to Aetna and your disenrollment is subject to Aetna’s termination date guidelines.

• Dental and Vision
  • Retiree dental and vision coverage MUST continue for a 12-month period based on your enrollment date. You may cancel retiree vision and/or retiree dental anytime as long as you have fulfilled at least the required 12-month period.

Re-Enrolling

• Medical
  • 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 the Medical Plan Enrollment Form and dependent supporting documentation is received by the HR Service Center. You can enroll in all other retiree medical plans ONLY during the annual Open Enrollment period with coverage effective the following January 1.

• Open Enrollment
  • Submit enrollment form(s) and dependent supporting documentation within the Open Enrollment period for changes to take effect the following January 1.
Enrollment Changes

- **Change in status**
  - Submit enrollment form(s) and dependent supporting documentation within 30 days

- **Open Enrollment**
  - Submit enrollment form(s) and dependent supporting documentation within the Open Enrollment period for changes to take effect the following January 1

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  - To terminate Aetna Medicare Plan (PPO) coverage, you must communicate your intentions directly to Aetna and your disenrollment is subject to Aetna’s termination date guidelines.

- **Dental and Vision**
  - Retiree dental and vision coverage MUST continue for a 12-month period based on your enrollment date. You may cancel retiree vision and/or retiree dental anytime as long as you have fulfilled at least the required 12-month period.

**Re-Enrolling**

- **Medical**
  - 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 the Medical Plan Enrollment Form and dependent supporting documentation is received by the HR Service Center. You can enroll in all other retiree medical plans ONLY during the annual Open Enrollment period with coverage effective the following January 1.

- **Open Enrollment**
  - Submit enrollment form(s) and dependent supporting documentation within the Open Enrollment period for changes to take effect the following January 1.
The following guidelines apply to retiree medical, dental and vision insurance benefits.

### Start and End Dates of Coverage

The following guidelines apply to retiree medical, dental and vision insurance benefits.

<table>
<thead>
<tr>
<th>For the Following Event</th>
<th>Time Limit</th>
<th>When Coverage Change Is Effective</th>
<th>Documents Required</th>
<th>Consequences of Missing the Time Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolling as a newly eligible Retiree or LTD Recipient</td>
<td>30 days from date of retirement or LTD eligibility (must have been enrolled in an active employee WSU plan at the time of retirement or LTD eligibility)</td>
<td>First of month following eligibility date</td>
<td>Enrollment form(s) and dependent supporting documentation</td>
<td>Only BCBS or HAP are 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 HR Service Center. Other carriers are not available until the next Open Enrollment period.</td>
</tr>
<tr>
<td>Enrolling as a newly eligible Surviving Spouse</td>
<td>30 days from date of death of retiree or active employee (must have been enrolled in WSU plan on date of death)</td>
<td>First of month following date of death</td>
<td>Enrollment form and copy of death certificate</td>
<td>Medical insurance is no longer available after initial enrollment eligibility period has passed.</td>
</tr>
<tr>
<td>Open Enrollment Changes</td>
<td>Within Open Enrollment period</td>
<td>January 1 of following year</td>
<td>Enrollment form(s) and dependent supporting documentation</td>
<td>Medical Plan Termination Form if canceling coverage</td>
</tr>
<tr>
<td>Adding dependent due to marriage, OEP relationship, birth or adoption</td>
<td>30 days from date of marriage, OEP relationship, birth or adoption</td>
<td>First of month following date of marriage or OEP relationship or Date of birth or adoption.</td>
<td>Enrollment form(s) and dependent supporting documentation</td>
<td>Only BCBS or HAP are 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 HR Service Center. Other carriers are not available until the next Open Enrollment period.</td>
</tr>
<tr>
<td>Cancelling coverage</td>
<td>Anytime (not applicable to dental or vision)</td>
<td>End of month following receipt of notification by the HR Service Center</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>Removing dependent due to divorce or termination of partnership</td>
<td>30 days from date of divorce or termination of partnership</td>
<td>End of month following date of divorce or termination of partnership</td>
<td>Medical Plan Termination Form and divorce decree</td>
<td>Cancellation cannot be made retroactively. Premiums paid for current coverage will not be refunded.</td>
</tr>
</tbody>
</table>

### Time Limit

- **Removing dependent due to dependent death**: 30 days from date of death
- **Removing dependent due to dependent’s loss of eligibility**: 30 days from date of dependent’s loss of eligibility
- **Enrolling due to becoming Medicare eligible (turning age 65 or as a disabled person)**: 30 days from date of Medicare eligibility (Aetna and HAP Senior Plus: within 3 months from becoming Medicare eligible)
- **Enrolling in new plan due to moving out of coverage area of current plan**: 30 days from date of moving out of coverage area
- **Enrolling due to loss of non-WSU coverage**: 30 days from date of loss of non-WSU coverage
- **Enrolling due to COBRA coverage ending**: 30 days from date of COBRA ending

### When Coverage Change Is Effective

- **End of month following date of death**
- **End of month following date of dependent’s loss of eligibility**
- **Effective date of Medicare coverage (Aetna and HAP Senior Plus: effective first of the month following receipt of required documents)**
- **Enrollment form(s) and copy of Medicare card showing parts A & B**

### Documents Required

- **Medical Plan Termination Form and copy of death certificate**
- **Medical Plan Termination Form and dependent supporting documentation**
- **Enrollment form(s) and dependent supporting documentation**

### Consequences of Missing the Time Limit

- **Cancellation cannot be made retroactively.**
- **Premiums paid for current coverage will not be refunded.**
- **Only BCBS or HAP are 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 HR Service Center. Other carriers are not available until the next Open Enrollment period.**
- **Only BCBS or HAP are 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 HR Service Center. Other carriers are not available until the next Open Enrollment period.**
- **Only BCBS or HAP are 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 HR Service Center. Other carriers are not available until the next Open Enrollment period.**

If a change in status action is not made within the allowable timeframe after the event, you won’t be able to make the change in status action until the next annual Open Enrollment period (absent another change in status), with coverage effective the following January 1.

All retiree benefits forms can be found in the **Retiree, Surviving Spouse and Long-Term Disability Recipient Benefits Enrollment Forms booklet**.
### Start and End Dates of Coverage

The following guidelines apply to retiree medical, dental and vision insurance benefits.

**For the Following Event** | **Time Limit** | **When Coverage Change is Effective** | **Documents Required** | **Consequences of Missing the Time Limit** |
--- | --- | --- | --- | --- |
Enrolling as a newly eligible Retiree or LTD Recipient | 30 days from date of retirement or LTD eligibility | First of month following eligibility date | Enrollment form(s) and dependent supporting documentation | Only BCBS or HAP are 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 HR Service Center. Other carriers are not available until the next Open Enrollment period. |
Enrolling as a newly eligible Surviving Spouse | 30 days from date of death of retiree or active employee (must have been enrolled in an active employee WSU plan at the time of retirement or LTD eligibility) | First of month following date of death | Enrollment form and copy of death certificate | Medical insurance is no longer available after initial enrollment eligibility period has passed. |
Open Enrollment Changes | Within Open Enrollment period | January 1 of following year | Enrollment form(s) and dependent supporting documentation Medical Plan Termination Form if canceling coverage | To enroll or make changes, must wait for a change in status or next Open Enrollment period to enroll. Can cancel medical at any time. |
Adding dependent due to marriage, OEP relationship, birth or adoption | 30 days from date of marriage, OEP relationship, birth or adoption | First of month following date of marriage or OEP relationship Date of birth or adoption. | Enrollment form(s) and dependent supporting documentation | Only BCBS or HAP are 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 HR Service Center. Other carriers are not available until the next Open Enrollment period. |
Cancelling coverage | Anytime (not applicable to dental or vision) | End of month following receipt of notification by the HR Service Center | Signed notification or Medical Plan Termination Form. | Cancellation cannot be made retroactively. Premiums paid for current coverage will not be refunded. |
Removing dependent due to divorce or termination of partnership | 30 days from date of divorce or termination of partnership | End of month following date of divorce or termination of partnership | Medical Plan Termination Form and divorce decree | Cancellation cannot be made retroactively. Premiums paid for current coverage will not be refunded. |

### For the Following Event

| **Time Limit** | **When Coverage Change is Effective** | **Documents Required** | **Consequences of Missing the Time Limit** |
--- | --- | --- | --- |
Removing dependent due to dependent's death | 30 days from date of death | End of month following date of death | Medical Plan Termination Form and copy of death certificate | Cancellation cannot be made retroactively. |
Removing dependent due to dependent's loss of eligibility | 30 days from date of dependent's loss of eligibility | End of month following date of dependent's loss of eligibility | Medical Plan Termination Form and dependent supporting documentation | Premiums paid for current coverage will not be refunded. |
Enrolling due to becoming Medicare eligible (turning age 65 or as a disabled person) | 30 days from date of Medicare eligibility (Aetna and HAP Senior Plus: within 3 months from becoming Medicare eligible) | Effective date of Medicare coverage (Aetna and HAP Senior Plus: effective first of the month following receipt of required documents) | Enrollment form(s) and copy of Medicare card showing parts A & B | Only BCBS or HAP are 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 HR Service Center. Other carriers are not available until the next Open Enrollment period. |
Enrolling in new plan due to moving out of coverage area of current plan | 30 days from date of moving out of coverage area | First of month following date of moving out of coverage area | Enrollment form(s) and proof of change of address | Only BCBS or HAP are 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 HR Service Center. Other carriers are not available until the next Open Enrollment period. |
Enrolling due to loss of non-WSU coverage | 30 days from date of loss of non-WSU coverage | First of month following date of loss of non-WSU coverage | Enrollment form(s) and proof of loss of non-WSU coverage | Only BCBS or HAP are 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 HR Service Center. Other carriers are not available until the next Open Enrollment period. |
Enrolling due to COBRA coverage ending | 30 days from date of COBRA ending | First of the month following date of COBRA ending | Enrollment form(s) and dependent supporting documentation | Only BCBS or HAP are 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 HR Service Center. Other carriers are not available until the next Open Enrollment period. |

If a change in status action is not made within the allowable timeframe after the event, you won’t be able to make the change in status action until the next annual Open Enrollment period (absent another change in status), with coverage effective the following January 1.

All retiree benefits forms can be found in the Retirement, Surviving Spouse and Long-Term Disability Recipient Benefits Enrollment Forms booklet.
Medical Plan Options

HAP Senior Plus (HMO)

The HAP Senior Plus (HMO), which is a Medicare Advantage plan, 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. You must choose a HAP Senior Plus affiliated physician. You can enroll in HAP Senior Plus (HMO) if you are enrolled in Medicare Parts A and B and live in the service area. However, individuals with End-Stage Renal Disease are generally not eligible to enroll in HAP Senior Plus (HMO) unless they were members of HAP HMO and have been since their dialysis began.

Please note: HAP Senior Plus (HMO) is available only to individuals with Medicare (Parts A and B). For two-person HAP Senior Plus (HMO) contracts, each person must have Medicare Parts A and B and complete a HAP Senior Plus enrollment form. Enrollment is subject to Medicare special enrollment/Open Enrollment guidelines. For more information regarding Medicare, please visit medicare.gov.

Aetna Medicare Plan (PPO)

The Aetna Medicare Plan (PPO), a Medicare Advantage Plan, 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. PPO members must ensure their provider will accept the PPO plan. Since the Aetna Medicare Plan (PPO) has an Extended Service Area, you won’t pay a higher cost when receiving covered services from non-network providers. You will receive all covered services at the in-network cost — unlike typical PPO plans.

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.

Please note: Aetna Medicare Plan (PPO) is available only to individuals with Medicare (Parts A and B). For two-person Aetna Medicare Plan (PPO) contracts, each person must have Medicare Parts A and B and complete an Aetna Medicare Advantage Plan enrollment form. Enrollment is subject to Medicare special enrollment/Open Enrollment guidelines. For more information regarding Medicare, please visit medicare.gov.

Virtual Doctor Visits

Virtual doctor visits is a service provided by the following medical plan options:
- Blue Care Network HMO
- Blue Cross Blue Shield Traditional Fee-for-Service Plan
- Health Alliance Plan HMO

This service provides medical consultation via telephone or internet for minor illnesses such as cold/flu symptoms, allergies and ear infections. Virtual doctor visits are available 24 hours a day, seven days a week. Physicians who consult virtually can issue prescription drugs for a variety of immediate care items, and can call the prescription in to the pharmacy you choose for easy pickup. Virtual consultations cost about the same as an office visit, without the limitation of office hours and the inconvenience of travel time. See the Benefits Resource Directory on page 2 for contact information, and the Comparison of Medical Benefits on pages 18-21 for the cost of this service.

Home Delivery Pharmacy Service

Home delivery pharmacy service (mail order) is available with each of the medical plan options to save you time and money. Generally, you can obtain a three-month supply of your medication for the cost of one copay (may vary based on your medical plan and the medication prescribed). For names and contact information for the individual services, see the Benefits Resource Directory on page 2. For more information on how the cost of mail order prescription drugs compare to retail cost, see the Comparison of Medical Benefits on pages 20-21.

Individuals Entitled to Medicare:

There is no annual deductible. The BCBS supplemental coverage is designed to cover the Medicare Parts 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, and 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.

Blue Care Network (HMO) and Health Alliance Plan (HMO)

HMOs 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. You must choose an affiliated 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.

Blue Care Network Coverage Area: All lower peninsula counties, except Schoolcraft

Health Alliance Plan Coverage Area: Arenac, Bay, Genesee, Hillsdale, Huron, Iosco, Jackson, Lapeer, Lenawee, Livingston, Macomb, Monroe, Oakland, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola, Washtenaw and Wayne Counties

Medical Plan Options

HAP Senior Plus (HMO)

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Please note: HAP Senior Plus (HMO) is available only to individuals with Medicare (Parts A and B). For two-person HAP Senior Plus (HMO) contracts, each person must have Medicare Parts A and B and complete a HAP Senior Plus enrollment form. Enrollment is subject to Medicare special enrollment/Open Enrollment guidelines. For more information regarding Medicare, please visit medicare.gov.

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Please note: Aetna Medicare Plan (PPO) is available only to individuals with Medicare (Parts A and B). For two-person Aetna Medicare Plan (PPO) contracts, each person must have Medicare Parts A and B and complete an Aetna Medicare Advantage Plan enrollment form. Enrollment is subject to Medicare special enrollment/Open Enrollment guidelines. For more information regarding Medicare, please visit medicare.gov.

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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, and 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.

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HMOs 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. You must choose an affiliated 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.

Blue Care Network Coverage Area: All lower peninsula counties, except Schoolcraft

Health Alliance Plan Coverage Area: Arenac, Bay, Genesee, Hillsdale, Huron, Iosco, Jackson, Lapeer, Lenawee, Livingston, Macomb, Monroe, Oakland, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola, Washtenaw and Wayne Counties
Medical Plan Options

HAP Senior Plus (HMO)
The HAP Senior Plus (HMO), which is a Medicare Advantage plan, 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. You must choose a HAP Senior Plus affiliated physician. You can enroll in HAP Senior Plus (HMO) if you are enrolled in Medicare Parts A and B and live in the service area. However, individuals with End-Stage Renal Disease are generally not eligible to enroll in HAP Senior Plus (HMO) unless they were members of HAP HMO and have been since their dialysis began.

If you select HAP Senior Plus (HMO), you only need to show your HAP Senior Plus ID card. You will not need to show your Medicare card when you obtain services.

Please note: HAP Senior Plus (HMO) is available only to individuals with Medicare (Parts A and B). For two-person HAP Senior Plus (HMO) contracts, each person must have Medicare Parts A and B and complete a HAP Senior Plus enrollment form. Enrollment is subject to Medicare special enrollment/Open Enrollment guidelines. For more information regarding Medicare, please visit medicare.gov.

Aetna Medicare Plan (PPO)
The Aetna Medicare Plan (PPO), a Medicare Advantage Plan, 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. PPO members must ensure their provider will accept the PPO plan. Since the Aetna Medicare Plan (PPO) has an Extended Service Area, you won’t pay a higher cost when receiving covered services from non-network providers. You will receive all covered services at the in-network cost — unlike typical PPO plans.

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.

Please note: Aetna Medicare Plan (PPO) is available only to individuals with Medicare (Parts A and B). For two-person Aetna Medicare Plan (PPO) contracts, each person must have Medicare Parts A and B and complete an Aetna Medicare Advantage Plan enrollment form. Enrollment is subject to Medicare special enrollment/Open Enrollment guidelines. For more information regarding Medicare, please visit medicare.gov.

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 (BCBS) 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 Parts 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, and 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.

Blue Care Network (HMO) and Health Alliance Plan (HMO)
HMOs 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. You must choose an affiliated 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.

Blue Care Network Coverage Area: All lower peninsula counties, except Schoolcraft
Health Alliance Plan Coverage Area: Arenac, Bay, Genesee, Hillsdale, Huron, Iosco, Jackson, Lapeer, Lenawee, Livingston, Macomb, Monroe, Oakland, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola, Washtenaw and Wayne Counties

Home Delivery Pharmacy Service
Home delivery pharmacy service (mail order) is available with each of the medical plan options to save you time and money. Generally, you can obtain a three-month supply of your medication for the cost of one copay (may vary based on your medical plan and the medication prescribed). For names and contact information for the individual services, see the Benefits Resource Directory on page 2. For more information on how the cost of mail order prescription drugs compare to retail cost, see the Comparison of Medical Benefits on pages 20-21.

Virtual Doctor Visits
Virtual doctor visits is a service provided by the following medical plan options:

• Blue Care Network HMO
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This service provides medical consultation via telephone or internet for minor illnesses such as cold/flu symptoms, allergies and ear infections. Virtual doctor visits are available 24 hours a day, seven days a week. Physicians who consult virtually can issue prescription drugs for a variety of immediate care items, and can call the prescription in to the pharmacy you choose for easy pickup. Virtual consultations cost about the same as an office visit, without the limitation of office hours and the inconvenience of travel time. See the Benefits Resource Directory on page 2 for contact information, and the Comparison of Medical Benefits on pages 18-21 for the cost of this service.
### 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>
</tr>
</thead>
<tbody>
<tr>
<td>Days of Care</td>
<td>Unlimited</td>
<td>365 Days</td>
</tr>
<tr>
<td>Room Type</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 deductible/coinsurance, extends inpatient days to 365 Days</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>
</tr>
<tr>
<td>Office Visits: In Person</td>
<td>Pays 90% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Telemedicine/Virtual Visits</td>
<td>Pays 90% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Routine Physical Examinations and Screenings</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Eye Examinations</td>
<td>Covered for disease or injury of eye and following cataract surgery</td>
<td>Routine eye exams not covered</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>
</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>
</tr>
<tr>
<td>Allergy Testing and Injections</td>
<td>Pays 90% of approved amount after deductible</td>
<td>Not covered</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>
</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>
</tr>
</tbody>
</table>

### Aetna Medicare Open™ Plan (PPO) vs. HAP (HMO) vs. HAP Senior Plus (HMO) vs. Blue Care Network (HMO)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Aetna Medicare Open™ Plan (PPO)</th>
<th>HAP (HMO)</th>
<th>HAP Senior Plus (HMO)</th>
<th>Blue Care Network (HMO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days of Care</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Room Type</td>
<td>Semi-private</td>
<td>Semi-private</td>
<td>Semi-private</td>
<td>Semi-private</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Surgery, Technical Surgical Assistance, Anesthesia, Medical Care</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Office Visits: In Person</td>
<td>Covered in full</td>
<td>$15 copay</td>
<td>$10 copay</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Telemedicine/Virtual Visits</td>
<td>Covered in full</td>
<td>$10 copay</td>
<td>Not covered</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Routine Physical Examinations and Screenings</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>
<td>Not covered</td>
</tr>
<tr>
<td>Eye Examinations</td>
<td>Covered in full</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Laboratory and Pathological Services</td>
<td>Covered in full</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Radiological Services (X-rays)</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Allergy Testing and Injections</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Outpatient Physical, Speech and Occupational Therapy</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Durable Medical Equipment &amp; Supplies as prescribed by a physician</td>
<td>Covered for authorized equipment</td>
<td>Covered in full for authorized equipment</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
</tbody>
</table>

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## 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>
</tr>
</thead>
<tbody>
<tr>
<td>Days of Care</td>
<td>Unlimited</td>
<td>365 Days</td>
</tr>
<tr>
<td>Room Type</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 deductible/coinsurance; extends inpatient days to 365 Days; New HAP Annual Part B deductible/coinsurance; non-emergency services must be rendered in a participating hospital</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>
</tr>
<tr>
<td>Office Visits: In Person</td>
<td>Pays 90% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Telemedicine/Virtual Visits</td>
<td>Pays 90% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Routine Physical Examinations and Screenings</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Eye Examinations</td>
<td>Covered for disease or injury of eye and following cataract surgery</td>
<td>Routine eye exams not covered</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>
</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>
</tr>
<tr>
<td>Allergy Testing and Injections</td>
<td>Pays 90% of approved amount after deductible</td>
<td>Not covered</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>
</tr>
<tr>
<td>Durable Medical Equipment &amp; Supplies</td>
<td>With doctor’s prescription pays 90% of approved amount after deductible</td>
<td>Pays Medicare deductible/coinsurance</td>
</tr>
</tbody>
</table>

### Aetna Medicare Open™ Plan (PPO) vs. HAP (HMO) vs. HAP Senior Plus (HMO) vs. Blue Care Network (HMO)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Aetna Medicare Open™ Plan (PPO)</th>
<th>HAP (HMO)</th>
<th>HAP Senior Plus (HMO)</th>
<th>Blue Care Network (HMO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days of Care</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Room Type</td>
<td>Semi-private</td>
<td>Semi-private</td>
<td>Semi-private</td>
<td>Semi-private</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Surgery, Technical Surgical Assistance, Anesthesia, Medical Care</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Office Visits: In Person</td>
<td>$15 copay</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Telemedicine/Virtual Visits</td>
<td>Not covered</td>
<td>$10 copay</td>
<td>Not covered</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Routine Physical Examinations and Screenings</td>
<td>Covered in full</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>Eye Examinations</td>
<td>Covered in full (one annual exam)</td>
<td>$10 copay for each office visit</td>
<td>$10 copay for each office visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>Laboratory and Pathological Services</td>
<td>$15 copay</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Radiological Services (X-rays)</td>
<td>$15 copay</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Allergy Testing and Injections</td>
<td>$15 copay</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>Outpatient Physical, Speech and Occupational Therapy</td>
<td>$15 copay</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>Durable Medical Equipment &amp; Supplies</td>
<td>15% coinsurance</td>
<td>Covered for authorized equipment</td>
<td>Covered in full for authorized equipment</td>
<td>Covered in full</td>
</tr>
</tbody>
</table>

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<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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail (1-month supply)</td>
<td>*$10 copay</td>
<td>*$10 copay</td>
</tr>
<tr>
<td>Home Delivery Pharmacy Service (3-month supply)</td>
<td>$10 copay</td>
<td>$10 copay</td>
</tr>
<tr>
<td><strong>Outpatient Mental Health Care &amp; Substance Abuse Treatment: In Person</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telemedicine/Virtual Visits</td>
<td>Plan pays 90% after deductible</td>
<td>Pays Medicare deductible/coinsurance</td>
</tr>
<tr>
<td></td>
<td>Plan pays 90% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Inpatient Mental Health Care &amp; Substance Abuse Treatment</td>
<td>Pays 90% of reasonable charge after deductible has been met</td>
<td>Pays Medicare deductible/coinsurance</td>
</tr>
<tr>
<td>Eyeglasses and Contact Lenses</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>Pays Medicare deductible/coinsurance following cataract surgery, intraocular surgery, accidental injury or certain non-routine diagnoses</td>
</tr>
<tr>
<td>Hearing Test</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Not covered</td>
<td>Not covered</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 5% 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.

## Aetna Medicare OpenSM Plan (PPO)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>HAP (HMO)</th>
<th>HAP Senior Plus (HMO)</th>
<th>Blue Care Network (HMO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Generic-Tier 1:</td>
<td>Generic: $5 copay</td>
<td>Preferred Generic-Tier 1:</td>
<td>Generic: $5 copay</td>
</tr>
<tr>
<td>Non-Preferred Generic-Tier 2:</td>
<td>Brand: $10 copay</td>
<td>Non-Preferred Generic-Tier 2:</td>
<td>Brand: $10 copay</td>
</tr>
<tr>
<td>Preferred Brand-Tier 3:</td>
<td></td>
<td>Preferred Brand-Tier 3:</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Brand-Tier 4:</td>
<td></td>
<td>Non-Preferred Brand-Tier 4:</td>
<td></td>
</tr>
<tr>
<td>Specialty Medications-Tier 5:</td>
<td>33% coinsurance</td>
<td>Specialty Medications-Tier 5:</td>
<td></td>
</tr>
<tr>
<td>Preferred Generic-Tier 1:</td>
<td>Generic: $5 copay</td>
<td>Preferred Generic-Tier 1:</td>
<td>Generic: $5 copay</td>
</tr>
<tr>
<td>Non-Preferred Generic-Tier 2:</td>
<td>Brand: $10 copay</td>
<td>Non-Preferred Generic-Tier 2:</td>
<td>Brand: $10 copay</td>
</tr>
<tr>
<td>Preferred Brand-Tier 3:</td>
<td></td>
<td>Preferred Brand-Tier 3:</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Brand-Tier 4:</td>
<td></td>
<td>Non-Preferred Brand-Tier 4:</td>
<td></td>
</tr>
<tr>
<td>Specialty Medications-Tier 5:</td>
<td>33% coinsurance</td>
<td>Specialty Medications-Tier 5:</td>
<td></td>
</tr>
<tr>
<td>Preferred Generic-Tier 1:</td>
<td>$15 copay</td>
<td>Preferred Generic-Tier 1:</td>
<td>$10 copay; covered according to Medicare guidelines</td>
</tr>
<tr>
<td>Non-Preferred Generic-Tier 2:</td>
<td>$10 copay</td>
<td>Non-Preferred Generic-Tier 2:</td>
<td></td>
</tr>
<tr>
<td>Preferred Brand-Tier 3:</td>
<td>$10 copay</td>
<td>Preferred Brand-Tier 3:</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Non-Preferred Brand-Tier 4:</td>
<td>$10 copay</td>
<td>Non-Preferred Brand-Tier 4:</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Specialty Medications-Tier 5:</td>
<td>$10 copay</td>
<td>Specialty Medications-Tier 5:</td>
<td>$10 copay</td>
</tr>
<tr>
<td><strong>Outpatient Mental Health Care &amp; Substance Abuse Treatment: In Person</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telemedicine/Virtual Visits</td>
<td>$10 copay</td>
<td>Covered at 100%</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Inpatient Mental Health Care &amp; Substance Abuse Treatment</td>
<td>$10 copay</td>
<td>Covered at 100% according to Medicare guidelines</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td>Eyeglasses and Contact Lenses</td>
<td>$15 copay</td>
<td>Covered at 100% according to Medicare guidelines</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td>Hearing Test</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Covered full following cataract surgery or to replace an organic lens because of congenital absence; only the initial prescription is covered</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Not covered</td>
<td>Not covered</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>
</tbody>
</table>

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## Benefit Blue Cross Blue Shield Without Medicare A & B Blue Cross Blue Shield With Medicare A & B

### Prescription Drugs
- **Retail (1-month supply)**
  - Preferred Generic-Tier 1: $2
  - Non-Preferred Generic-Tier 2: $10
  - Preferred Brand-Tier 3: $40
  - Non-Preferred Brand-Tier 4: $75
  - Specialty Medications-Tier 5: 33% coinsurance

- **Home Delivery Pharmacy Service (3-month supply)**
  - Preferred Generic-Tier 1: $5
  - Non-Preferred Generic-Tier 2: $5
  - Preferred Brand-Tier 3: $10
  - Non-Preferred Brand-Tier 4: $10
  - Specialty Medications-Tier 5: 33% coinsurance

### Outpatient Mental Health Care & Substance Abuse Treatment: In Person
- Plan pays 90% after deductible
- Pays Medicare deductible/coinsurance

### Telemedicine/Virtual Visits
- Plan pays 90% after deductible
- Not covered

### Inpatient Mental Health Care & Substance Abuse Treatment
- Pays 90% of reasonable charge after deductible has been met
- Pays Medicare deductible/coinsurance

### Eyeglasses and Contact Lenses
- Pays 90% of reasonable charge after deductible has been met following cataract surgery, intraocular surgery, accidental injury or certain non-routine diagnoses
- Pays Medicare deductible/coinsurance following cataract surgery, intraocular surgery, accidental injury or certain non-routine diagnoses

### Hearing Test
- Not covered

### Hearing Aids
- Not covered

---

* 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 5% 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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### Comparison of Medical Benefits

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### Aetna Medicare OpenSM Plan (PPO)
- Preferred Generic-Tier 1: $2
- Non-Preferred Generic-Tier 2: $10
- Preferred Brand-Tier 3: $40
- Non-Preferred Brand-Tier 4: $75
- Specialty Medications-Tier 5: 33% coinsurance

### HAP (HMO)
- Generic: $5 copay
- Brand: $10 copay

### HAP Senior Plus (HMO)
- Preferred Generic-Tier 1: $5
- Non-Preferred Generic-Tier 2: $5
- Preferred Brand-Tier 3: $10
- Non-Preferred Brand-Tier 4: $10
- Specialty Medications-Tier 5: 10%

### Blue Care Network (HMO)
- Generic: $5 copay
- Brand: $10 copay

---

* 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 5% 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.
<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>
</tr>
</thead>
<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>
</tr>
<tr>
<td>Skilled Nursing Care Facility</td>
<td>Not Covered</td>
<td>Pays Medicare daily coinsurance for 21st through 100th day.</td>
</tr>
<tr>
<td>Annual Deductibles</td>
<td>$100 per person $200 per family</td>
<td>$0</td>
</tr>
<tr>
<td>Copays</td>
<td>10% unless otherwise noted, $10 prescription copay</td>
<td>$10 prescription copay</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 ($1,000 per family) All cost sharing limited to $600 individual, $1,200 family</td>
<td>$0</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Hospital Pre-Certification</td>
<td>Required - physician responsibility</td>
<td>Required - physician responsibility</td>
</tr>
</tbody>
</table>

**Aetna Medicare OpenSM Plan (PPO)**

- Covered in full after copay: Urgent Care Provider $15 copay Emergency Room $50 copay; (waived if admitted) Ambulance $15 copay
- Covered up to 730 days, renewable after 60 days, excludes custodial care
- Covered up to 730 days per benefit period, excludes custodial care

**HAP (HMO)**

- Covered in full; should notify primary care physician or health plan within 48 hours of admission
- Covered up to 730 days, renewable after 60 days, excludes custodial care

**HAP Senior Plus (HMO)**

- Covered in full; must notify primary care physician or health plan within 48 hours of admission
- Covered up to 730 days per benefit period, excludes custodial care

**Blue Care Network (HMO)**

- Covered in full; must notify primary care physician or health plan within 48 hours of admission
- Covered up to 730 days per episode of illness, excludes custodial care

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<tr>
<th>Benefit</th>
<th>Aetna Medicare OpenSM Plan (PPO)</th>
<th>HAP (HMO)</th>
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</thead>
<tbody>
<tr>
<td>Emergency Services (Life-Threatening Medical Emergencies or Accidents ONLY)</td>
<td>Covered in full after copay: Urgent Care Provider $15 copay; Emergency Room $50 copay; (waived if admitted) Ambulance $15 copay</td>
<td>Covered in full; should notify primary care physician or health plan within 48 hours of admission</td>
<td>Covered in full; should notify primary care physician or health plan within 48 hours of admission</td>
<td>Covered in full; must notify primary care physician or health plan within 48 hours of admission</td>
</tr>
<tr>
<td>Skilled Nursing Care Facility</td>
<td>Not Covered</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Annual Deductibles</td>
<td>$100 per person</td>
<td>$100 per person</td>
<td>$100 per person</td>
<td>$100 per person</td>
</tr>
<tr>
<td>Copays</td>
<td>10% unless otherwise noted, $10 prescription copay</td>
<td>$10 prescription copay</td>
<td>$10 prescription copay</td>
<td>$10 prescription copay</td>
</tr>
<tr>
<td>Annual Maximum Out-of-Pocket (includes deductible, coinsurance and copays)</td>
<td>$2,000 prescription copay limited to $500 per person per year ($1,000 per family)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>Unlimited</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>Required - physician responsibility</td>
<td>Required - physician responsibility</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.
Medicare is the health insurance program sponsored by the federal government for persons age 65 and over (and for certain disabled persons). The following parts make up Medicare:

- **Part A**: Hospital insurance that covers reasonable and medically necessary inpatient hospitalization, some skilled nursing facility expenses and hospice care. It is financed by separate employee and company payroll taxes. Normally, the hospital accepts Medicare’s payment and you will not pay additional fees other than any applicable deductible.

- **Part B**: Covers medically-necessary physician and surgeon services, outpatient hospital, home health service, diagnostic tests, some of the services of physical and occupational therapists and other medical benefits. The cost of this part of the Medicare program is paid by you and matched by an equal contribution from federal general funds collected from taxpayers.

- **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 and prescription drug coverage through the plan. In most Medicare Advantage plans, there are extra benefits and lower copayments 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. WSU has two Medicare Advantage Plans: Aetna Medicare Plan (PPO) and HAP Senior Plus (HMO).

- **Part D**: Provides prescription drug benefits. You choose the plan (provided by a private company) and you pay a monthly premium. If you have limited income and resources, you may qualify to get this coverage for little or no cost. 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 becomes available on the first day of the month in which you reach age 65 — or the first day of the previous month if your birth date is the first of the month — whether you're retired, on LTD or still working. Medicare also becomes available after you have been receiving Social Security disability benefits for two years or if you have been diagnosed with end-stage renal disease.

Most people should enroll in Part A when they turn 65, even if they haven’t retired yet and/or have health insurance from an employer. This is because most people pay Medicare taxes while they work so they don't pay a monthly premium for Part A. If you or your eligible dependent becomes eligible for Medicare, it’s your responsibility to contact Medicare regarding eligibility and enrollment.

**How WSU Retiree Medical Plans Interact with Medicare**

When you or an eligible dependent becomes eligible for and enrolls in Medicare Parts A and B, you must provide a copy of your Medicare card within 30 calendar days to the HR Service Center. If the HR Service Center isn’t notified within this 30-day period, any medical claims that were processed by the WSU plan without Medicare payment information may be reprocessed. If it is determined that the claim was overpaid, you may be required to reimburse the plan for any overpayment you received.

WSU retiree medical plans (HAP, Blue Care Network, and BCBS) are “secondary” to Medicare Parts A and B. This means Medicare pays benefits before the WSU plan pays. The WSU plan will only pay for services covered by Medicare after Medicare has paid their portion.

The Aetna Medicare Advantage Plan (PPO) and HAP Senior Plus (HMO) Plan replace traditional Medicare.

As soon as you or your covered dependent becomes eligible for Medicare, you or your covered dependent MUST enroll in Medicare Parts A and B to be entitled to all of the benefits provided under your WSU plan.

**Important Note Regarding Medicare Part D**: WSU Retiree prescription drug coverage cannot be coordinated with Medicare Part D prescription drug coverage (i.e. cannot pay on a secondary basis). If you currently have prescription drug coverage through a WSU retiree medical plan, you can choose not to enroll in Medicare Part D. WSU retiree coverage is considered “creditable coverage.” Creditable coverage means the prescription drug coverage has been determined to be at least as good as Medicare prescription drug 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.

For More Information on Medicare

We encourage you to learn more about Medicare and your options by visiting mymedicare.gov. The 800-MEDICARE helpline is there for you 24 hours a day, including weekends. TTY users should call 877-486-2048.

Medicare
Medicare

Medicare is the health insurance program sponsored by the federal government for persons age 65 and over (and for certain disabled persons). The following parts make up Medicare:

- **Part A**: Hospital insurance that covers reasonable and medically necessary inpatient hospitalization, some skilled nursing facility expenses and hospice care. It is financed by separate employee and company payroll taxes. Normally, the hospital accepts Medicare’s payment and you will not pay additional fees other than any applicable deductible.

- **Part B**: Covers medically-necessary physician and surgeon services, outpatient hospital, home health service, diagnostic tests, some of the services of physical and occupational therapists and other medical benefits. The cost of this part of the Medicare program is paid by you and matched by an equal contribution from federal general funds collected from taxpayers.

- **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 and prescription drug coverage through the plan. In most Medicare Advantage plans, there are extra benefits and lower copayments 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. WSU has two Medicare Advantage Plans: Aetna Medicare Plan (PPO) and HAP Senior Plus (HMO).

- **Part D**: Provides prescription drug benefits. You choose the plan (provided by a private company) and pay a monthly premium. If you have limited income and resources, you may qualify to get this coverage for little or no cost. 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 becomes available on the first day of the month in which you reach age 65 — or the first day of the previous month if your birth date is the first of the month — whether you’re retired, on LTD or still working. Medicare also becomes available after you have been receiving Social Security disability benefits for two years or if you have been diagnosed with end-stage renal disease.

Most people should enroll in Part A when they turn 65, even if they haven’t retired yet and/or have health insurance from an employer. This is because most people pay Medicare taxes while they work so they don’t pay a monthly premium for Part A. If you or your eligible dependent becomes eligible for Medicare, it’s your responsibility to contact Medicare regarding eligibility and enrollment.

How WSU Retiree Medical Plans Interact with Medicare

When you or an eligible dependent becomes eligible for and enrolls in Medicare Parts A and B, you must provide a copy of your Medicare card within 30 calendar days to the HR Service Center. If the HR Service Center isn’t notified within this 30-day period, any medical claims that were processed by the WSU plan without Medicare payment information may be reprocessed. If it is determined that the claim was overpaid, you may be required to reimburse the plan for any overpayment you received.

WSU retiree medical plans (HAP, Blue Care Network, and BCBS) are “secondary” to Medicare Parts A and B. This means Medicare pays benefits before the WSU plan pays. The WSU plan will only pay for services covered by Medicare after Medicare has paid their portion.

The Aetna Medicare Advantage Plan (PPO) and HAP Senior Plus (HMO) Plan replace traditional Medicare. As soon as you or your covered dependent becomes eligible for Medicare, you or your covered dependent MUST enroll in Medicare Parts A and B to be entitled to all of the benefits provided under your WSU plan.

Important Note Regarding Medicare Part D: WSU Retiree prescription drug coverage cannot be coordinated with Medicare Part D prescription drug coverage (i.e. cannot pay on a secondary basis). If you currently have prescription drug coverage through a WSU retiree medical plan, you can choose not to enroll in Medicare Part D. WSU retiree coverage is considered “creditable coverage.” Creditable coverage means the prescription drug coverage has been determined to be at least as good as Medicare prescription drug 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.
Dental Insurance

You may elect to enroll yourself and eligible dependents in the WSU retiree dental plan, offered by Delta Dental. The plan provides you and your family with coverage for regular dental checkups, preventive care and other services to keep your teeth and gums healthy. Provide your Social Security number when you receive dental services. Delta Dental does not issue ID cards.

Once you elect retiree dental insurance, coverage MUST remain in effect for 12 months, based on your enrollment date. Your coverage will be renewed annually automatically.

The following chart outlines a summary of coverages for each type of provider. The percentages below are applied to Delta Dental’s allowance for each service and it may vary due to the dentist’s network participation.* The benefit year runs January 1 through December 31.

Summary of Dental Plan Benefits For Group # 5989-0001

<table>
<thead>
<tr>
<th>Category</th>
<th>Delta Dental PPO Dentist</th>
<th>Delta Dental Premier Dentist</th>
<th>Nonparticipating Dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic &amp; Preventative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic and Preventative</td>
<td>100%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Services – exams, cleanings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and fluoride</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brush Biopsy – to detect oral</td>
<td>100%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bitewing Radiographs –</td>
<td>100%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>bitewing X-rays</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space Maintainers – appliances</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>to prevent tooth movement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Palliative Treatment</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>to temporarily relieve pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Other Radiographs – other</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>X-rays</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor Restorative Services</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>– fillings and crown repair</td>
<td></td>
<td></td>
<td></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</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>gum disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Surgery Services</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>extractions and dental surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Basic Services – misc.</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restines and Repairs – to bridges, implants and dentures</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

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.

You and your eligible dependents must enroll for a minimum of 12 months. If coverage is terminated after 12 months, you may not re-enroll prior to the annual Open Enrollment period that occurs at least 12 months from the date of termination. Plan changes are only allowed during annual Open Enrollment periods, except that an election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

If a retiree or dependent terminates 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.

Benefits will cease on the last day of the month in which the employee terminates coverage.

Please Note

Your dependents may only enroll in dental insurance coverage if you are enrolled (except under COBRA) and must be enrolled in the same plan as you.

Dental Insurance

You may elect to enroll yourself and eligible dependents in the WSU retiree dental plan, offered by Delta Dental. The plan provides you and your family with coverage for regular dental checkups, preventive care and other services to keep your teeth and gums healthy. Provide your Social Security number when you receive dental services. Delta Dental does not issue ID cards.

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<td>50%</td>
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<td></td>
<td></td>
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Benefits will cease on the last day of the month in which the employee terminates coverage.

Additional coverage information:

- 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 are payable once in any seven-year period.
- Implants are payable once per tooth in any seven-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any seven-year period. Services related to crowns over implants are Covered Services.

Please Note

Your dependents may only enroll in dental insurance coverage if you are enrolled (except under COBRA) and must be enrolled in the same plan as you.
Dental Insurance

You may elect to enroll yourself and eligible dependents in the WSU retiree dental plan, offered by Delta Dental. The plan provides you and your family with coverage for regular dental checkups, preventive care and other services to keep your teeth and gums healthy. Provide your Social Security number when you receive dental services. Delta Dental does not issue ID cards.

Once you elect retiree dental insurance, coverage MUST remain in effect for 12 months, based on your enrollment date. Your coverage will be renewed annually automatically.

The following chart outlines a summary of coverages for each type of provider. The percentages below are applied to Delta Dental’s allowance for each service and it may vary due to the dentist’s network participation.* The benefit year runs January 1 through December 31.

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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic and Preventive Services – exams, cleanings and fluoride</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>
<tr>
<td>Basic Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space Maintainers – appliances to prevent tooth movement</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
</tr>
<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>
<tr>
<td>Major Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Restorative Services – crowns</td>
<td>40%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Prosthodontic Services – bridges, implants and dentures</td>
<td>40%</td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>

* 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. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

Please Note
Your dependents may only enroll in dental insurance coverage if you are enrolled (except under COBRA) and must be enrolled in the same plan as you.

Additional coverage information:
- 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.
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- Bridges are payable once in any seven-year period.
- Implants are payable once per tooth in any seven-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any seven-year period. Services related to crowns over implants are Covered Services.

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.

You and your eligible dependents must enroll for a minimum of 12 months. If coverage is terminated after 12 months, you may not re-enroll prior to the annual Open Enrollment period that occurs at least 12 months from the date of termination. Plan changes are only allowed during annual Open Enrollment periods, except that an election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

If a retiree or dependent terminates 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.

Benefits will cease on the last day of the month in which the employee terminates coverage.
Vision Insurance

You may elect to enroll yourself and eligible dependents in vision insurance offered by EyeMed Vision Care. This program provides discounts through a national network of eye care professionals using the SELECT network.

The vision plan offers two options: the Basic Plan and Enhanced Buy-Up Plan. Each plan has annual allowed services and copays. Discounts for eyewear are received at the time of purchase, and all charges are handled directly between you and the discount provider. Provide your Banner ID when you receive eye care services. EyeMed does not issue ID cards.

Once you elect retiree vision insurance, either Basic or Enhanced Buy-Up, coverage will remain in effect for 12 months based on your enrollment date. Your coverage will be renewed annually automatically.

<table>
<thead>
<tr>
<th>Vision Care Services</th>
<th>Basic Plan</th>
<th>Enhanced Buy-Up Plan</th>
<th>Basic/Enhanced</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>In-Network</td>
<td>Out-of-Network Reimbursement</td>
</tr>
<tr>
<td>Exam with dilation as necessary</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>Up to $35</td>
</tr>
<tr>
<td>Retinal imaging Benefits</td>
<td>Up to $39</td>
<td>Up to $39</td>
<td>N/A</td>
</tr>
<tr>
<td>Contact Lens Fit and Follow-Up:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Premium</td>
<td>10% off retail price</td>
<td>$0 copay, paid-in-full fit and two follow-up visits</td>
<td>N/A / $40</td>
</tr>
<tr>
<td>Frames</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>Standard Plastic Lenses:</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, 80% of charge less $120 allowance</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>Lens Options: (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>Contact Lenses (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 plus balance over $115</td>
<td>$0 copay, $150 allowance plus 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>Up to $200</td>
</tr>
<tr>
<td>LASIK and PRK Vision Correction Procedures</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>Amplifon Hearing Health Care</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>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>
<tr>
<td>Frequency:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam</td>
<td>Once every calendar year</td>
<td>Once every calendar year</td>
<td>Once every calendar year</td>
</tr>
<tr>
<td>Frames</td>
<td>Standard Plastic Lenses or Contact Lenses</td>
<td>Standard Plastic Lenses or Contact Lenses</td>
<td>Standard Plastic Lenses or Contact Lenses</td>
</tr>
</tbody>
</table>
**Vision Insurance**

You may elect to enroll yourself and eligible dependents in vision insurance offered by EyeMed Vision Care. This program provides discounts through a national network of eye care professionals using the SELECT network. The vision plan offers two options: the Basic Plan and Enhanced Buy-Up Plan. Each plan has annual allowed services and copays. Discounts for eyewear are received at the time of purchase, and all charges are handled directly between you and the discount provider. Provide your Banner ID when you receive eye care services. EyeMed does not issue ID cards.

Once you elect retiree vision insurance, either Basic or Enhanced Buy-Up, coverage will remain in effect for 12 months based on your enrollment date. Your coverage will be renewed annually automatically.

### Vision Care Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Basic Plan</th>
<th>Enhanced Buy-Up Plan</th>
<th>Basic/Enhanced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam with dilation as necessary</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>Up to $35</td>
</tr>
<tr>
<td>Retinal imaging Benefits</td>
<td>Up to $39</td>
<td>Up to $39</td>
<td>N/A</td>
</tr>
<tr>
<td>Contact Lens Fit and Follow-Up:</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 price</td>
<td>$0 copay, 10% off retail price, then apply $40 allowance</td>
<td>N/A / $40</td>
</tr>
<tr>
<td>Frames</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>Standard Plastic Lenses:</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, 80% of charge less $120 allowance</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Premium Progressive</td>
<td>$55 copay, 80% of charge less $120 allowance</td>
<td>N/A / $40</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Lens Options: (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>Contact Lenses (allowance covers materials only):</td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>Conventional</td>
<td>$0 copay, $115 allowance; 15% off balance over $115</td>
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<td></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
**COBRA**

In the event of retirement, becoming LTD eligible or becoming a surviving spouse, your medical, dental and/or vision coverage under WSU’s active-employee plan will end. Retiring employees, surviving spouses of deceased active employees, and LTD recipients have the option to choose continuation of active-employee coverage under federal legislation known as COBRA. COBRA information and enrollment material is sent out by the university’s COBRA administrator, Arcadia (acquired by Navia Benefits). Your COBRA package will allow you to elect to continue the group health coverage you received on an active employee plan (as an employee yourself or as a spouse) for a specified period. Terms and conditions of COBRA enrollment will be outlined in your package. Time limits apply for enrollment. Questions regarding COBRA enrollment should be directed to Arcadia (acquired by Navia Benefits).

If you do elect COBRA, you may still elect retiree medical, dental and/or vision benefits during or upon termination of your COBRA period.

**Important to note:**

- If you will turn 65 during the COBRA period, you should enroll in Medicare Part B when eligible.
  - Your COBRA medical benefits will terminate. COBRA dental and vision benefits will continue.
  - You will be eligible for retiree medical benefits.
- If you are 65 or older, you should enroll in Medicare Part B when active employee benefits terminate to avoid penalties.
- It is not recommended to have Medicare and COBRA since both will be primary and benefits are not coordinated. You will be eligible for retiree benefits upon termination of COBRA. Enrollment forms must be received by the HR Service Center within 30 days of the COBRA termination.

COBRA rates are available online at wayne.edu/tcw/health-welfare/medical-rates.

For more information about COBRA, please visit: dol.gov/general/topic/health-plans/cobra.

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**Life Insurance**

As a retiree, the university provides you with life insurance coverage at no cost to you. The amount is determined by your date of retirement. Eligible individuals who retired on or after July 1, 1968 have a $2,500 policy. Participants who participated in an Early Retirement Incentive Program may have a $25,000 policy.

Please note: You may convert a portion of the life insurance coverage you are losing as an active employee to an individual direct-pay plan. The conversion form is available from the HR Service Center or at wayne.edu/tcw/health-welfare/life-insurance. Time limits apply: If you have questions about the conversion procedure or the rates, please call Sun Life Financial at 800-247-6875.

**Your Beneficiary(ies)**

You must name a beneficiary (the person or persons designated to receive the life insurance benefits in the event of your death). You may name as many beneficiaries as you wish — including individual persons, your estate, a trust, church or charitable organizations. Please provide tax IDs for non-person designations.

- If you designate more than one beneficiary without identifying their respective shares, the beneficiaries will share equally.
- When designating your beneficiary(ies), provide the Social Security number and as much information as possible (e.g., full name, date of birth, current address).
- By law, benefits cannot be paid directly to a minor (anyone under age 18) or a legally incompetent person — benefits will be paid to the court-appointed guardian. In the absence of a court-appointed guardian, the Claims Administrator will hold the proceeds until the minor reaches age 18.
- If your marriage status changes (divorce, re-marriage, etc.), you may wish to make a new valid beneficiary designation. Advising the university of your status change does NOT change your beneficiary designation. If you named your spouse as your beneficiary prior to your divorce, your divorce does not automatically revoke your election. You must complete and submit the Retiree & LTD Life Insurance Beneficiary Designation Form.
- Unless you specify otherwise, the interest of any beneficiary who dies before you, at the same time as you, or within 24 hours of your death, will be paid as described below.

**If You Don’t Have a Beneficiary**

The Claims Administrator may pay all or part of the benefits due in the following order:

- Your spouse, if alive;
- Your child(ren), if there is no surviving spouse;
- Your parent(s), if there is no surviving child;
- Your sibling(s), if there is no surviving parent; or
- Your estate, if there is no surviving sibling.

If you would like to update your life insurance beneficiaries, please complete the Life Insurance Beneficiary Designation Form found in the Retiree, Surviving Spouse and Long-Term Disability Recipient Benefits Enrollment Forms booklet.
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#### Your Beneficiary(ies)
You must name a beneficiary (the person or persons designated to receive the life insurance benefits in the event of your death). You may name as many beneficiaries as you wish — including individual persons, your estate, a trust, church or charitable organizations. Please provide tax IDs for non-person designations.

- If you designate more than one beneficiary without identifying their respective shares, the beneficiaries will share equally.
- When designating your beneficiary(ies), provide the Social Security number and as much information as possible (e.g., full name, date of birth, current address).
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- Your spouse, if alive;
- Your child(ren), if there is no surviving spouse;
- Your parent(s), if there is no surviving child;
- Your sibling(s), if there is no surviving parent; or
- Your estate, if there is no surviving sibling.

If you would like to update your life insurance beneficiary, please complete the Life Insurance Beneficiary Designation Form found in the [Retiree, Surviving Spouse and Long-Term Disability Recipient Benefits Enrollment Forms booklet](wayne.edu/tcw/health-welfare/life-insurance).
How to File a Death Claim
The HR Service Center is the initial point of contact for all claim submissions under the WSU retiree life insurance plan. Your beneficiary will be provided a Claimant Package that must be completed and returned to the HR Service Center along with a copy of the death certificate.

Certified copies of the death certificates are required for claims of $249,000 or greater and/or when issued outside of the U.S. Other documents (for example, a copy of trust or estate documents) may also be required, depending on your beneficiary designations. The claimant will be advised if additional documents are needed to support a claim.

A complete package, which includes the Employer Information and the Claimant Package, is required before the insurance company will process the claim.

When reporting the death to the HR Service Center, the following information regarding the deceased must be provided:
• Name
• Social Security number
• Date of death

Retirement Savings Plans
Retirees: Contact your 403(b) and/or 457(b) carrier to learn about your options as you retire. For example, you can:
1. Leave your funds in the plan and take advantage of other services offered to participants
2. Rollover your account(s)
3. Take a cash withdrawal (subject to tax implications)
4. Start an annuity
5. Accept minimum distribution at age 70½

Long-Term Disability Recipients: If you were participating in the WSU 403(b) retirement savings plan on the date of disability, the LTD insurance carrier will continue to contribute up to 15% of your last day of work salary to your retirement account. This is known as the Monthly Annuity Contribution Benefit. For information on the distribution options available to you, please contact your 403(b) carrier. Note: Receiving a full distribution will terminate your retirement account and thereby stop your Monthly Annuity Contribution Benefit.

Other Retiree Benefits
Voluntary Benefits
Voluntary benefits you were previously enrolled in as an employee can be continued during retirement. If you have Liberty Mutual home and/or automobile insurance or long-term care insurance with John Hancock or Trustmark that was deducted from your payroll prior to retirement, please contact the respective company two to three weeks before your date of retirement to change to home billing.

Vacation and Illness Bank Payoffs
Employees in certain classifications are eligible for a payoff of their vacation days and one-half of their accumulated illness bank up to a maximum of 30 days' pay. Please refer to your labor contract or the non-represented employee personnel manual for details. The payoff is included in your last check as an active employee.

OneCard
A retiree OneCard 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 OneCard also allows you to join the Mort Harris Recreation and Fitness Center ($252 annually) or use the facilities on a daily basis ($10 per visit). To apply for a retiree OneCard, please contact the OneCard/Parking Service Center (313-577-2273) after your date of retirement.

Free Parking
As a retiree, you are eligible for free university parking in Parking Structures 1-8, with the exception of structure 6. Have your OneCard with you as you are entering the parking structures. No action is required on your part if you have already been in touch with the HR Service Center with your Letter of Retirement. If you have issues, contact the OneCard/Parking Service Center (313-577-2273).

AccessID
Your AccessID and email account will remain active after you retire or become a long-term disability recipient. You will continue to have access to Academica and your email. No action is required on your part if you have already been in touch with the HR Service Center with your Letter of Retirement. If you have issues, contact the C&IT helpdesk at 313-577-4357 or helpdesk@wayne.edu.
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Educational Opportunities
Students 60 years of age or older on the first day of classes for the semester are entitled to a 75% reduction of the regular tuition rate. Students are responsible for the entire amount of the Registration Fee, Fitness Center Fee, Student Service Fees and any class-related fees. Eligible students must submit proof of age (e.g., copy of Michigan driver's license or birth certificate) to Records and Registration located at 5057 Woodward, 5th Floor, Detroit, 48202. The document can also be faxed to 313-577-7870. Please include name and AccessID number. If additional information is needed, contact the Student Service Center at 313-577-2100 or by email at studentservice@wayne.edu.

In addition, you may wish to enroll in SOAR (Society of Active Retirees) for a nominal fee. Classes are offered through WSU Educational Outreach at Adat Shalom Synagogue in Farmington Hills. For more information, please call 248-626-0296 or visit SOAR's website at soarexplre.com.

Social Security
For information regarding Social Security Retirement benefits, you may drop by your local Social Security Administration office, call their toll-free number at 800-772-1213, or visit their website at ssa.gov.

Legal Notices
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 coinsurance applicable to other medical and surgical benefits provided under each of the university-sponsored medical plans.

Noticex of Availability of Notice of Privacy Practices
The Wayne State University group health plan (the “Plan”) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan’s Notice of Privacy Practices, contact the HR Service Center at 313-577-3000.

HIPAA Notice of Special Enrollment Rights
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the department of Benefits & Wellness. The Children’s Health Insurance Program Reauthorization Act of 2009 added the following two special enrollment opportunities:

- The employee’s or dependent’s Medicaid or CHIP (Children’s Health Insurance Program) coverage is terminated as a result of loss of eligibility.
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

It is your responsibility to notify the department of Benefits & Wellness within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. More information on CHIP is provided below.

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)
If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed on pages 36-37, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are not currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 877-KIDS-NOW or visit insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at askbsa.dol.gov or call 866-444-EBSA (3272).
hipaa notice of special enrollment rights

if you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). however, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

in addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. however, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

to request special enrollment or obtain more information, contact the department of benefits & wellness.

the children’s health insurance program reauthorization act of 2009 added the following two special enrollment opportunities:

• the employee’s or dependent’s medicaid or chip (children’s health insurance program) coverage is terminated as a result of loss of eligibility.

• the employee or dependent becomes eligible for a premium assistance subsidy under medicaid or chip.

it is your responsibility to notify the department of benefits & wellness within 60 days of the loss of medicaid or chip coverage, or within 60 days of when eligibility for premium assistance under medicaid or chip is determined. more information on chip is provided below.

premium assistance under medicaid and the children’s health insurance program (chip)

if you or your children are eligible for medicaid or chip and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage using funds from their medicaid or chip programs. if you or your children aren’t eligible for medicaid or chip, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the health insurance marketplace. for more information, visit healthcare.gov.

if you or your dependents are already enrolled in medicaid or chip and you live in a state listed on pages 36-37, contact your state medicaid or chip office to find out if premium assistance is available.

if you or your dependents are not currently enrolled in medicaid or chip, and you think you or any of your dependents might be eligible for either of these programs, contact your state medicaid or chip office or dial 877-kidsnow or visit insurekidsnow.gov to find out how to apply. if you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

if you or your dependents are eligible for premium assistance under medicaid or chip, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. this is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. if you have questions about enrolling in your employer plan, contact the department of labor at askbsa.dol.gov or call 866-444-ebqa (3272).

educational opportunities

students 60 years of age or older on the first day of classes for the semester are entitled to a 75% reduction of the regular tuition rate. students are responsible for the entire amount of the registration fee, fitness center fee, student service fees and any class-related fees. eligible students must submit proof of age (e.g., copy of michigan driver’s license or birth certificate) to records and registration located at 5057 woodward, 5th floor, detroit, 48202. the document can also be faxed to 313-577-7870. please include name and accessid number. if additional information is needed, contact the student service center at 313-577-2100 or by email at studentservice@wayne.edu.

in addition, you may wish to enroll in soar (society of active retirees) for a nominal fee. classes are offered through wsu educational outreach at adat shalom synagogue in farmington hills. for more information, please call 248-626-0296 or visit soar’s website at soarexplor.com.

legal notices

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 coinsurance applicable to other medical and surgical benefits provided under each of the university-sponsored medical plans.

notice of availability of notice of privacy practices

the wayne state university group health plan (the “plan”) maintains a notice of privacy practices that provides information to individuals whose protected health information (phi) will be used or maintained by the plan. if you would like a copy of the plan’s notice of privacy practices, contact the hr service center at 313-577-3000.

social security

for information regarding social security retirement benefits, you may drop by your local social security administration office, call their toll-free number at 800-772-1213, or visit their website at ssa.gov.
If you live in one of the states listed below, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: myalh Hipp.com/
Phone: 855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: myakhipp.com/
Phone: 866-251-6961
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: myarh Hipp.com/
Phone: 855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: healthfirstcolorado.com/CHIP-Website:
Phone: 800-539-1991/State Relay 711
Customer Service: 800-221-3943/ State Relay 711

FLORIDA – Medicaid
Website: fmmedicaidptrecovery.com/hipp/
Phone: 877-357-3268

GEORGIA – Medicaid
Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid
Medicaid Program) & Child Health Plan Plus (CHP+)
Website: dphhs.alaska.gov/dpa/Pages/medicaid/default.aspx
Email: CustomerService@MyAKHIPP.com
Phone: 866-251-6961
Medicaid Eligibility: dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

KANSAS – Medicaid
Website: kdhkgs.gov/hcf/
Phone: 785-296-3512

KENTUCKY – Medicaid
Website: chfs.ky.gov
Phone: 800-635-2570

LOUISIANA – Medicaid
Website: dsh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 888-695-2447

MAINE – Medicaid
Website: maine.gov/dhhs/oi/public-assistance/index.html
Phone: 800-642-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: mass.gov/eohhs/doi/blshealthcareprograms/CHIP+Website:
Phone: 800-862-4840

MINNESOTA – Medicaid
Website: mn.gov/dhs/people-serve/seniors/health-care/health-care-programs/other-insurance.jsp
Phone: 800-657-3739

MISSOURI – Medicaid
Website: dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800-694-3084

NEBRASKA – Medicaid
Website: ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Website: dhcfp.mv.gov/
Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid
Website: dhhs.nh.gov/oi/hipp.htm
Phone: 603-271-5218
Toll-free number for the HIPP program:
800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: state.nj.us/humanservices/dmahi/clients/medicaid/CHIP Website: njfamilycare.org/index.html
CHIP Phone: 800-701-0710

NEW YORK – Medicaid
Website: health.ny.gov/healthcare/medicaid/
Phone: 800-541-2831

NORTH CAROLINA – Medicaid
Website: medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: nd.gov/dhs/services/medicalsev/medicaid/CHIP Website: insurend.com/
Phone: 844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: insureoklahoma.org
Phone: 888-365-3742

OREGON – Medicaid
Website: healthcare.oregon.gov/Pages/index.aspx
oregonhealthcare.gov/index.es.html
Phone: 800-699-9075

PENNSYLVANIA – Medicaid
Website: coverva.org/programs/premium_assistance.cfm
Medicaid Phone: 609-631-2392
CHIP Website: coverva.org/programs_premium_assistance.cfm
CHIP Phone: 855-242-8282

WASHINGTON – Medicaid
Website: hca.wa.gov/
Phone: 800-362-3022, ext.1547

WYOMING – Medicaid
Website: wyqualitycare.acs-inc.com/
Phone: 307-777-7531

NEW HAMPSHIRE – Medicaid
Website: dhhs.nh.gov/oi/hipp.htm
Phone: 603-271-5218
Toll-free number for the HIPP program:
800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: state.nj.us/humanservices/dmahi/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: njfamilycare.org/index.html
CHIP Phone: 800-701-0710

NEW YORK – Medicaid
Website: health.ny.gov/healthcare/medicaid/
Phone: 800-541-2831

NORTH CAROLINA – Medicaid
Website: medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: nd.gov/dhs/services/medicalsev/medicaid/CHIP Website: insurend.com/
Phone: 844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: insureoklahoma.org
Phone: 888-365-3742

OREGON – Medicaid
Website: healthcare.oregon.gov/Pages/index.aspx
oregonhealthcare.gov/index.es.html
Phone: 800-699-9075

PENNSYLVANIA – Medicaid
Website: coverva.org/programs/premium_assistance.cfm
Medicaid Phone: 609-631-2392
CHIP Website: coverva.org/programs_premium_assistance.cfm
CHIP Phone: 855-242-8282

WASHINGTON – Medicaid
Website: hca.wa.gov/
Phone: 800-362-3022, ext.1547

WYOMING – Medicaid
Website: wyqualitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:
• U.S. Dept. of Labor, Employee Benefits Security Administration:
dol.gov/agencies/ebsa
Phone: 866-444-EBSA (3272)
• U.S. Dept. of Health and Human Services, Centers for Medicare & Medicaid Services:
cms.hhs.gov
Phone: 877-267-2323, Menu Option 4, Extension 61565

SOUTH CAROLINA – Medicaid
Website: scdhhs.gov
Phone: 888-549-0820

SOUTH DAKOTA – Medicaid
Website: dss.sd.gov
Phone: 888-828-0059

TEXAS – Medicaid
Website: gethipptexas.com/
Phone: 800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: medicaid.utah.gov/
CHIP Website: health.utah.gov/chip
Phone: 877-543-7669

WISCONSIN – Medicaid
Website: dss.wisconsin.gov/publications/tp10005.pdf
Phone: 800-362-3002

VERMONT – Medicaid
Website: greenmountaincare.org/
Phone: 800-250-8427

WYOMING – Medicaid
Website: myalh Hipp.com/
Phone: 855-MyARHIPP (855-692-7447)

• U.S. Dept. of Health and Human Services, Centers for Medicare & Medicaid Services:

dhs.iowa.gov/hawk-i
Website: dhss.iowa.gov/hawk-i
Phone: 800-257-8563

• U.S. Dept. of Labor, Employee Benefits Security Administration:
dol.gov/agencies/ebsa
Phone: 866-444-EBSA (3272)

• U.S. Dept. of Health and Human Services, Centers for Medicare & Medicaid Services:
cms.hhs.gov
Phone: 877-267-2323, Menu Option 4, Extension 61565

36
37
As a WSU Retiree, What Are Your Options Under the WSU Medical Insurance Plan?

You can elect to continue your WSU medical insurance coverage and NOT enroll in Medicare Part D.

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.

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).

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.

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 the following 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.

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

Contact our office at 313-577-3000. 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 changes 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 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 800-MEDICARE (800-633-4227). TTY users should call 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 socialsecurity.gov, or you can call them at 800-772-1213 (TTY 800-325-0778).
Creditable Coverage Notice (Medicare Part D)

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.

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 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.

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.

As a WSU Retiree, What Are Your Options Under the WSU Medical Insurance Plan?

You can elect to continue your WSU medical insurance coverage and NOT enroll in Medicare Part D.

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.

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).

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.

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 the following 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.

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

Contact our office at 313-577-3000. 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 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 800-MEDICARE (800-633-4227). TTY users should call 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 socialsecurity.gov, or you can call them at 800-772-1213 (TTY 800-325-0778).
Benefits & Wellness • Human Resources

Address: 5700 Cass Ave., Suite 3638, Detroit, Michigan 48202
Telephone: 313-577-3000 • Fax: 313-577-0637 • Email: askhr@wayne.edu
Web: hr.wayne.edu/tcw

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