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RHCT

Retiree Health Care Trust

CTA Retiree Health Care Plan

2022

ENROLLMENT GUIDE

*for Retirees, Disabled Pensioners,
Surviving Spouses and Dependents*

Medical, Prescription Drug and Dental Coverage

January 1, 2022 - December 31, 2022

SEE DOWNTOWN MAP



RETIREE HEALTH BENEFITS ENROLLMENT GUIDE
for coverage from January 1, 2022, through December 31, 2022

Contact Information

| Plan | Phone Number and Web Address |
|--|--|
| Retiree Health Care Plan Administration Group Administrators, Ltd. | Phone: 866.997.3821 Fax: 847.519.1979 www.groupadministrators.com |
| Pre-Medicare PPO Plan Blue Cross and Blue Shield of Illinois (BCBSIL) PPO | 800.292.6398 bcbsil.com |
| Wellbeing Management Enable (WBM) Program (precertification) | 800.247.9204 bcbsil.com |
| CVS Caremark (prescription drugs with BCBS PPO) | 888.797.8897 www.caremark.com |
| Pre-Medicare HMO Illinois Plan HMO Illinois | 800.892.2803 bcbsil.com |
| Prime Therapeutics (prescription drugs with HMO IL) | 800.423.1973 www.primetherapeutics.com |
| BCBS Blue 365 Discount Program EyeMed Vision | 866.273.0813 |
| Medicare Plans Humana Medicare Advantage and Prescription Drug Plans | 800.542.2070 (TTY: 711) humana.com/ctarhct |
| Dental Plans MetLife | 800.942.0854 metlife.com/mybenefits |
| CTA Retirement Office | 866.441.9694 or 312.441.9694 ctaretirement.org |



RETIREE HEALTH BENEFITS ENROLLMENT GUIDE for coverage from January 1, 2022, through December 31, 2022

TO CHANGE YOUR COVERAGE, YOU MUST ENROLL FOR BENEFITS BY NOVEMBER 12, 2021

**THE COVERAGE YOU CHOOSE NOW WILL REMAIN IN EFFECT
FROM JANUARY 1, 2022, THROUGH
DECEMBER 31, 2022,
SO MAKE YOUR SELECTIONS CAREFULLY**

Please read the information in this guide thoroughly.

1. Review the enclosed 2021 Statement of Benefits. It shows your current elections and your current enrolled dependents.
2. If you want to keep your current coverage, **DO NOTHING**. You do not need to re-enroll.
3. If you want to make changes, complete the enclosed enrollment form, and return it to Group Administrators in the envelope provided, so it arrives by November 15.

Introduction

The CTA Retiree Health Care Plan (the Plan) includes medical, prescription drug and dental coverage for CTA retirees and disabled pensioners, surviving spouses and eligible dependents. The elections you make during open enrollment (November 1 – November 12, 2021) will be effective January 1 – December 31, 2022. Your elections will stay in effect through December 31, 2022, unless you have a qualifying event, described on page 7.

About Your Plans and Costs for 2022

2022 medical plan and dental plan coverage will stay the same as 2021 coverage. However, 2022 medical plan and dental plan premiums will either decrease or remain the same as 2021 premiums.

Even though there are no medical plan or dental plan coverage changes for 2022, be sure to review the 2022 premiums and all other information in this enrollment guide carefully before making any decisions about your 2022 coverage. If you are married, please share this guide with your spouse.

This guide highlights some features of the medical, prescription drug and dental plans. If a conflict arises between the information in this enrollment guide and any Plan provisions, the terms of the actual Plan documents or other applicable documents will govern in all cases. Any aspect of the Retiree Health Care Plan can be changed at any time, at the discretion of the Board of Trustees.



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The Open Enrollment Process

This open enrollment guide includes general information that applies to everyone, information that applies to those who **are not** eligible for Medicare and information that applies to those who **are** eligible for Medicare. These sections each have different color bars at the top of their respective pages:

GRAY BAR applies to *all participants*

LIGHT PURPLE BAR applies to *non-Medicare-eligible participants*

DARK PURPLE BAR applies to *Medicare-eligible participants*

Use the enclosed envelope to return your completed enrollment form. It must be postmarked by November 12, 2021.

Key things to remember:

- Your enrollment elections will be effective from January 1, 2022, through December 31, 2022.
- To make changes, you must return a completed enrollment form, and **it must be postmarked by Friday, November 12, 2021.**
- If you do not enroll or you miss the enrollment deadline, your current coverage as shown on the enclosed 2021 Statement of Benefits will continue until December 31, 2022.
- You will receive a notice in December confirming your coverage and the monthly contribution you will pay.

Please carefully review all the information in this enrollment guide before making any decisions.

As you review the guide, be sure you understand:

- The eligibility rules for dependents and for opting out of coverage. See pages 6 and 8.
- How the Plan's medical options work and the differences between them.
- The contributions you will pay for medical coverage, based on the medical option and coverage level you elect.
- The Plan's dental options. See page 29 for details. **NOTE:** You do **not** have to enroll for medical coverage to receive dental coverage.

When you are ready to enroll, follow the instructions on page 32 to complete the enrollment form.

When you are ready to enroll, follow the instructions on page 32 to complete the enrollment form.



Important Information About the Plan

Eligibility

Retirees who elect health care coverage for themselves may also enroll their eligible spouses and/or dependent children.

Surviving spouses who elect health care coverage for themselves may also enroll their eligible dependent children.

Eligible Spouse

An “eligible spouse” includes your legally married spouse, same-sex domestic partner or civil union partner, if he or she meets the eligibility requirements. If your spouse is enrolling in the Plan **after** July 1, 2009, your spouse is eligible if he or she was your spouse for at least one year before the date of your separation from employment with the CTA.

Eligible Dependent Children

- Any natural child, adopted child or stepchild through age 25, who:
 - Is unmarried; **and**
 - Resides with the retiree (if the child is age 19 or older); **and**
 - Is dependent upon the retiree for over half of his or her financial support.
- Any unmarried dependent through age 29 who is an Illinois resident and a military veteran **and**:
 - Has served in the U.S. armed forces (including the National Guard); **and**
 - Has received a release or discharge other than a dishonorable discharge; **and**
 - Lives with the retiree when not deployed; **and**
 - Is dependent upon the retiree for over half of his or her financial support.
- Any child named as an alternate recipient in a Qualified Medical Child Support Order (QMCSO).
- A child of any age who was disabled before age 26, was covered under the Plan before reaching the limiting age **and is**:
 - Incapable of self-sustaining employment; **and**
 - Is dependent upon the retiree or other care provider for lifetime care and supervision because of the disability.

When you enroll any new dependent in the Plan, you must provide supporting documentation, such as:

- A birth certificate;
 - Adoption papers;
 - Court orders; or
 - Armed forces discharge papers.
-



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Voluntarily opting out of coverage under another medical plan, if you are still eligible for coverage under that plan, is not considered a qualifying event for enrolling in this Plan.

If you or your dependent becomes eligible for Medicare before age 65 due to a disability, contact Group Administrators immediately; your pre-Medicare coverage under the Plan will end, and you must elect a Medicare plan.

A child who is temporarily away at school but continues to have the same permanent address as the retiree is considered to live with the retiree.

Changing Your Health Benefits

Open Enrollment

You can change your benefit elections during the open enrollment period, November 1, 2021, through November 12, 2021. The coverage you choose will be effective January 1, 2022, through December 31, 2022.

Qualifying Event

Once you enroll or change your coverage because of a qualifying event, your coverage will be effective from the date of the qualifying event through December 31, 2022. Examples of qualifying events include, but are not limited to, the following:

- You lose coverage under another plan. You will be allowed to enroll yourself and any eligible dependents who were covered under the other plan, as applicable.
- Your eligible spouse and/or dependent child(ren) lose coverage under another plan. You will be allowed to add the dependent(s) and change to family coverage, if necessary.
- You become eligible for Medicare.
- Your eligible spouse (if you are a retiree) or dependent child(ren) become eligible for Medicare.
- You die. Your eligible spouse will be able to convert to surviving spouse coverage, with or without eligible dependents.
- Your dependent(s) are no longer eligible for coverage, or one of your dependent(s) dies.
- You or your spouse gives birth or adopts a child.

To change your coverage, you or your dependent(s) must notify Group Administrators, the Plan's administrator, within 30 days of the qualifying event to change your coverage. If you or your eligible dependents enroll in the Plan, you/they must also provide documentation indicating that you/they were covered under another medical plan immediately before the date you/they enroll for coverage under this Plan.

If you or your dependent(s) do not have a qualifying event, you may not change your health care elections until the next open enrollment period, for coverage effective January 1, 2023.



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Opting Out of Coverage

Each eligible person (retiree, spouse or dependent child) may opt out of coverage or drop coverage and return to the Plan **only one time** after January 1, 2010. In addition to open enrollment, the circumstances under which an eligible person can return to the Plan are described in the previous section.

If a retiree or surviving spouse opts out of medical coverage, that person's dependents are not eligible for coverage under the medical plan.

Anyone who opts out of medical coverage and then joins or returns to the Plan after January 1, 2010, must provide a certificate of creditable coverage or other proof indicating that they had coverage under another medical plan within 63 days before having coverage under this Plan. Coverage will be effective on the first of the month following notification of the loss of coverage.

Affordable Care Act—Marketplace (Exchange)

The Affordable Care Act (also known as “Obamacare” or “the ACA”) created health care exchanges (also known as the Marketplace) for anyone who wants coverage. The Marketplace provides health care coverage choices in your area.

If You Are Eligible for Medicare

If you **are** eligible for Medicare, you cannot buy coverage from the Marketplace. You can always choose to opt out of the CTA RHCT Plan and choose a different Medicare plan. If you elect ANY Medicare coverage (including supplemental coverage) outside of the Medicare Advantage plans provided by the CTA RHCT, you will lose coverage in the CTA RHCT Medicare plans. **You can return to the CTA RHCT Plan only once in a lifetime.**

If You Are Not Eligible for Medicare

If you are not eligible for Medicare, you can go to the Marketplace to compare health care coverage and contributions. If you find a plan that suits your family's needs better than the Plan's coverage, you can buy that coverage from the Marketplace. However, **if you buy coverage from the Marketplace, you cannot be covered under the CTA RHCT Plan; you can return to the Plan only once in your lifetime.**

How Do I Shop for Coverage or Get Help?

- ✓ Marketplace open enrollment is November 1, 2021 – December 15, 2021 (for coverage effective January 1, 2022).
- ✓ To shop for coverage, visit healthcare.gov. Or call 800.318.2596 (TTY: 855.889.4325) to speak with a representative who can help you enroll by phone. You can also request that the representative send you a paper application.
- ✓ Online chat help (**/contact-us**) and telephone help are available 24/7.

The Pre-Medicare Medical Benefit Options

The Plan offers two medical options through Blue Cross and Blue Shield (BCBS):

1. The Blue Cross and Blue Shield of Illinois PPO (BCBSIL)
2. HMO Illinois (HMOI)

All your family members who are not eligible for Medicare must be enrolled in the same non-Medicare medical option.

Both the PPO and HMO offer a network of health care providers who have agreed to charge lower, negotiated fees for their services. However, there are important differences between the two plans, highlighted below.

The PPO Option

The Blue Cross and Blue Shield of Illinois (BCBSIL) PPO option has an extensive provider network in Illinois. It includes a majority of Illinois physicians and hospitals.

Under the PPO, you can receive care from any doctor or hospital. However, if you see network providers, you pay less for care. Network providers have agreed with Blue Cross and Blue Shield of Illinois to charge less for their services. So, you and the Plan save money when you use network providers. When you use non-network providers, the fees for their services will be higher, and you will receive benefits at a lower level than when you use network providers. Also, non-network providers may balance bill you—that is, they will bill you for the difference between their full charge and the payment they receive from the Plan.

How the PPO Option Works

Before the Plan pays any benefits, you must pay for initial charges up to a deductible of **\$390** per person or **\$780** per family. Each covered person has to meet a **\$390** deductible; however, if the combined expenses of two or more people in a family reach **\$780**, no further deductibles will be required of any family member for the rest of the calendar year.

Once the annual deductible is met, the Plan starts paying benefits for covered expenses for the person who has met the deductible, or for all covered family members, as applicable. Generally, the Plan pays 90% for in-network expenses, and you pay 10%. For out-of-network expenses, the Plan pays 60%, and you pay 40%.



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Once your annual out-of-pocket expenses (coinsurance plus copayments) reach the individual or family annual out-of-pocket maximums, the Plan will pay 100% of covered expenses for the remainder of the calendar year.

See the **Comparison Chart** on pages 12 - 14 for information about annual deductibles, copayments and out-of-pocket maximums.

Examples on page 15 illustrate how the deductibles, coinsurance percentages and annual out-of-pocket maximums work for individual and family coverage in the PPO option. Note: These examples assume services were received from network providers.

Prescription Drug Coverage Under the PPO Option

The PPO option includes a prescription drug benefit, administered by CVS Caremark. Prescription drug coverage includes mandatory mail order. Mail-order service is easy, convenient and will save you money on maintenance medications. These are prescription drugs you take regularly, such as blood pressure or cholesterol medication. You must fill prescriptions for maintenance medications through any CVS retail store or the mail-order service after receiving your first refill.

After receiving an initial 30-day supply of a maintenance medication, you can **refill it once** at a retail pharmacy. After your first refill, ask your doctor for a second prescription for a 90-day supply of medication along with the appropriate number of refills (normally three refills, which is a year's worth of medication). You must fill this second prescription through any CVS retail pharmacy or the mail-order service.

The HMO Option

The HMO Illinois option has an extensive network of physicians and hospitals within Illinois, **including Northwestern Memorial Hospital and physicians.**

Under the HMO Illinois option, you must choose a primary care physician (PCP) for you and each covered family member. You can change your PCP at any time. Your PCP will coordinate your medical care with other physicians in the HMO Illinois network. If you need to see a specialist or have a procedure, your PCP must provide a referral. The Plan will pay benefits only for care received from providers in the HMO Illinois network. Otherwise, the Plan will not pay benefits (except for emergencies).

When you get your first refill of a maintenance drug, ask your doctor for a second prescription that you will fill through any CVS retail pharmacy or the mail-order service.

Mail-order forms are available from Group Administrators, at www.caremark.com, or by calling CVS Caremark Member Services: 888.797.8897.

Under the HMO option, you must choose a primary care physician (PCP) in the HMO Illinois network for yourself and each of your enrolled dependents.

How the HMO Plan Works

Most services received from an HMO Illinois PCP or from an HMO Illinois network provider, to which you are referred by your PCP, are covered 100%; an annual deductible and coinsurance are not required. Certain network services, such as doctors’ office visits, may require a small copayment at the time of service.

Prescription Drug Coverage Under the HMO Option

The HMO Illinois option offers prescription drug coverage administered by Prime Therapeutics. The **Comparison Chart** on page 14 summarizes the HMO Illinois drug benefits.

PPO or HMO: Which Plan Is Right for You?

| PLAN TYPE | CONSIDER THE FOLLOWING: |
|------------|--|
| PPO | <ul style="list-style-type: none"> • Are your doctors and other providers in the BCBSIL PPO network? • Do you and/or your enrolled dependents need medical services from providers outside the state of Illinois? • Is the option to choose any medical provider important to you? • Are you willing to pay more for care from non-network providers if you need non-network care? |
| HMO | <ul style="list-style-type: none"> • Are your doctors and other providers in the HMO Illinois network? • Are you comfortable with having to get a referral from your PCP each time you need care from other network providers? • Are you okay with not receiving benefits if you see a provider outside the HMO Illinois network (except for emergencies)? |



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Comparison Chart

| | BLUE CROSS AND BLUE SHIELD OF ILLINOIS | | |
|---|--|--|---|
| | PPO | | HMO Illinois (In-Network Only) |
| | IN-NETWORK | OUT-OF-NETWORK | |
| Individual Annual Deductible | \$390 individual / \$780 family per calendar year | | Not applicable |
| Lifetime Maximum | \$2,000,000 per person | | Unlimited |
| Annual Out-of-Pocket Maximum (includes psychiatric and substance abuse) | \$3,901 individual / \$7,803 family | \$5,202 individual / \$10,404 family | \$1,500 individual / \$3,000 family |
| OUTPATIENT SERVICES | | | |
| Physician Office Visits (accident or illness) | 90% after deductible | 60% of eligible charges after deductible | Covered 100% after \$10 copayment per visit |
| Diagnostic Services (lab tests and x-rays) | 90% after deductible | 60% of eligible charges after deductible | Covered 100% |
| Outpatient Surgery | 90% after deductible | 60% of eligible charges after deductible | Covered 100% |
| Routine Physical Examinations | 100% up to \$1,500 maximum per person per year (includes mammograms, Pap smears, colonoscopies); then, subject to deductible, coinsurance and out-of-pocket maximums | | Covered 100% after \$10 copayment per visit |
| Injections and Immunizations | Covered under routine physical examinations benefit | | Covered 100% |
| Pediatric Care | 90% after deductible | 60% of eligible charges after deductible | Covered 100% after \$10 copayment per visit |
| Eye Care (EyeMed only: 866.273.0813) | Blue 365 Discount Program: Discounts on eye exams and corrective eyewear | Not available | Eye exam covered 100% after \$10 copayment; \$75 allowance toward pair of glasses or contact lenses every 2 years |
| EMERGENCY SERVICES | | | |
| | You must obtain Blue Cross and Blue Shield of Illinois approval by calling 800.247.9204 within 1 working day, if admitted to the hospital; otherwise, your benefits will decrease by 20% | | Primary care physician must be contacted, except for emergencies |
| Emergency Room (worldwide; waived if admitted) | \$130 copayment; waived if admitted | | Covered 100% after \$100 copayment per visit; copayment waived if admitted |
| Ambulance | 90% of eligible charges after deductible; you must obtain Blue Cross and Blue Shield of Illinois approval by calling 800.247.9204 | | Covered 100% if an emergency or if ordered by HMO Illinois |



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| | BLUE CROSS AND BLUE SHIELD OF ILLINOIS | | |
|--|--|--|--|
| | PPO | | HMO Illinois (In-Network Only) |
| | IN-NETWORK | OUT-OF-NETWORK | |
| HOSPITAL INPATIENT SERVICES | | | |
| Limit on Days | None | | None |
| Hospital Expenses | 90% after deductible | 60% of eligible charges after deductible | Covered 100%; private room provided when medically necessary |
| Surgery and Anesthesia | 90% after deductible | 60% of eligible charges after deductible | Covered 100% |
| Doctor and Specialist Services | 90% after deductible | 60% of eligible charges after deductible | Covered 100% |
| Obstetrical Services | 90% after deductible | 60% of eligible charges after deductible | Covered 100% |
| OTHER SERVICES | | | |
| Maternity Care | 90% after deductible | 60% of eligible charges after deductible | Covered 100% |
| Skilled Nursing Care | 90% after deductible | 60% of eligible charges after deductible | Covered 100% |
| Home Health Care or Private Duty Nurse (up to 40 visits per calendar year) | 90% after deductible | 60% of eligible charges after deductible | Covered 100% |
| Physical Therapy | 90% after deductible | 60% of eligible charges after deductible | Short-term covered 100% up to 60 visits per year |
| Family Planning | Not covered | Not covered | Covered |
| Extended Care | 90% after deductible | 60% of eligible charges after deductible | Covered 100%, based on medical necessity; custodial care not covered |
| Prosthetic Appliances and Durable Medical Equipment | 90% after deductible | 60% of eligible charges after deductible | Covered 100% |
| Transplant Services | 90% after deductible | 60% of eligible charges after deductible | Contact HMO Illinois |



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| BLUE CROSS AND BLUE SHIELD OF ILLINOIS | | | |
|---|---|---|---|
| PPO | | | HMO Illinois (In-Network Only) |
| | IN-NETWORK | OUT-OF-NETWORK | |
| BEHAVIORAL HEALTH SERVICES | | | |
| Before receiving mental health or chemical dependency treatment, or within one business day of an emergency admission, you must call BCBS for authorization: 800.292.6398 | | | |
| Mental Health: Inpatient | 90% after deductible | 60% of eligible charges after deductible | Covered 100% |
| Chemical Dependency: Inpatient | 90% after deductible for employees only; no dependent coverage | 60% of eligible charges, after deductible, for employees only; no dependent coverage | Covered 100% for employees only; no dependent coverage |
| You must call BCBS for authorization (800.292.6398) within one working day of an emergency admission; otherwise, your benefits will be reduced by 20% | | | |
| Mental Health: Outpatient | 90% after deductible | 60% of eligible charges after deductible | Covered 100% after \$10 copayment per visit |
| Chemical Dependency: Outpatient | 90% after deductible, for employees only; no dependent coverage | 60% of eligible charges, after deductible, for employees only; no dependent coverage | Covered 100% after \$10 copayment per visit, for employees only; no dependent coverage |
| PRESCRIPTION DRUG BENEFIT | | | |
| You may use any retail pharmacy for one-time prescriptions. All maintenance prescription drugs are limited to one retail refill. After the first refill, you must fill your prescription(s) through the Mail Service Pharmacy (PPO or HMO Illinois) or a CVS Caremark retail pharmacy (for PPO only: mail-order discount applies). PRESCRIPTION DRUG BENEFITS UNDER BCBSIL PPO ARE ADMINISTERED BY CVS CAREMARK. PRESCRIPTION DRUG BENEFITS UNDER HMO ILLINOIS ARE ADMINISTERED BY PRIME THERAPEUTICS. | | | |
| Generic | | | Generic |
| Retail (up to a 30-day supply) | \$13 copayment | | \$5 copayment |
| Mail Order (up to a 90-day supply) | \$26 copayment | | \$10 copayment |
| Brand Name Drugs on the Formulary List (if no generic) | | | Preferred |
| Retail (up to a 30-day supply) | \$26 copayment | | \$10 copayment |
| Mail Order (up to a 90-day supply) | \$52 copayment | | \$20 copayment |
| Brand Name Drugs Not on the Formulary or Brand Name Drugs with a Generic Equivalent Available (if no generic) | | | Non-Preferred |
| Retail (up to a 30-day supply) | \$65 copayment | | \$25 copayment |
| Mail Order (up to a 90-day supply) | \$130 copayment | | \$50 copayment |



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PPO Plan Examples

PPO EXAMPLE 1: INDIVIDUAL COVERAGE

Sam needed a covered outpatient procedure in January. He used a network provider, and the procedure cost \$1,800. This was Sam's first medical expense during the year. Here is how the Plan would pay:

| | |
|-------------------|-------------|
| Covered expense | \$1,800 |
| Sam's deductible | <u>-390</u> |
| Remaining expense | \$1,410 |
| Plan pays 90% | \$1,269 |
| Sam pays 10% | \$141 |

In total, the Plan would pay \$1,269, and Sam would pay \$531 (deductible plus 10%). The \$531 Sam paid would count toward his annual out-of-pocket maximum of \$3,901.

If Sam did not use a network provider, his costs would have been \$390 (deductible) plus 40% of a higher expense, because there was no PPO discount (at least \$564), for a total of at least \$954.

PPO EXAMPLE 2: FAMILY COVERAGE

Sara and her family had a number of medical expenses during the first few months of the year. They all used network providers. Here is how the Plan would pay:

| | Sara's Expenses | Mark's Expenses | Julie's Expenses | Total for Sara's Family |
|---------------------------|------------------------|------------------------|-------------------------|--------------------------------|
| 1. Covered expenses | \$2,500 | \$750 | \$1,500 | \$4,750 |
| 2. Family deductibles | <u>-390</u> | <u>-390</u> | <u>\$0*</u> | -780 |
| 3. Remaining expenses | \$2,110 | \$360 | \$1,500 | \$3,970 |
| 4. Plan pays 90% | \$1,899 | \$324 | \$1,350 | \$3,573 |
| 5. Sara's family pays 10% | \$211 | \$36 | \$150 | \$397 |
| Total Plan pays (4) | \$1,899 | \$324 | \$1,350 | \$3,573 |
| Total family pays (2 + 5) | \$601 | \$426 | \$150 | \$1,177 |

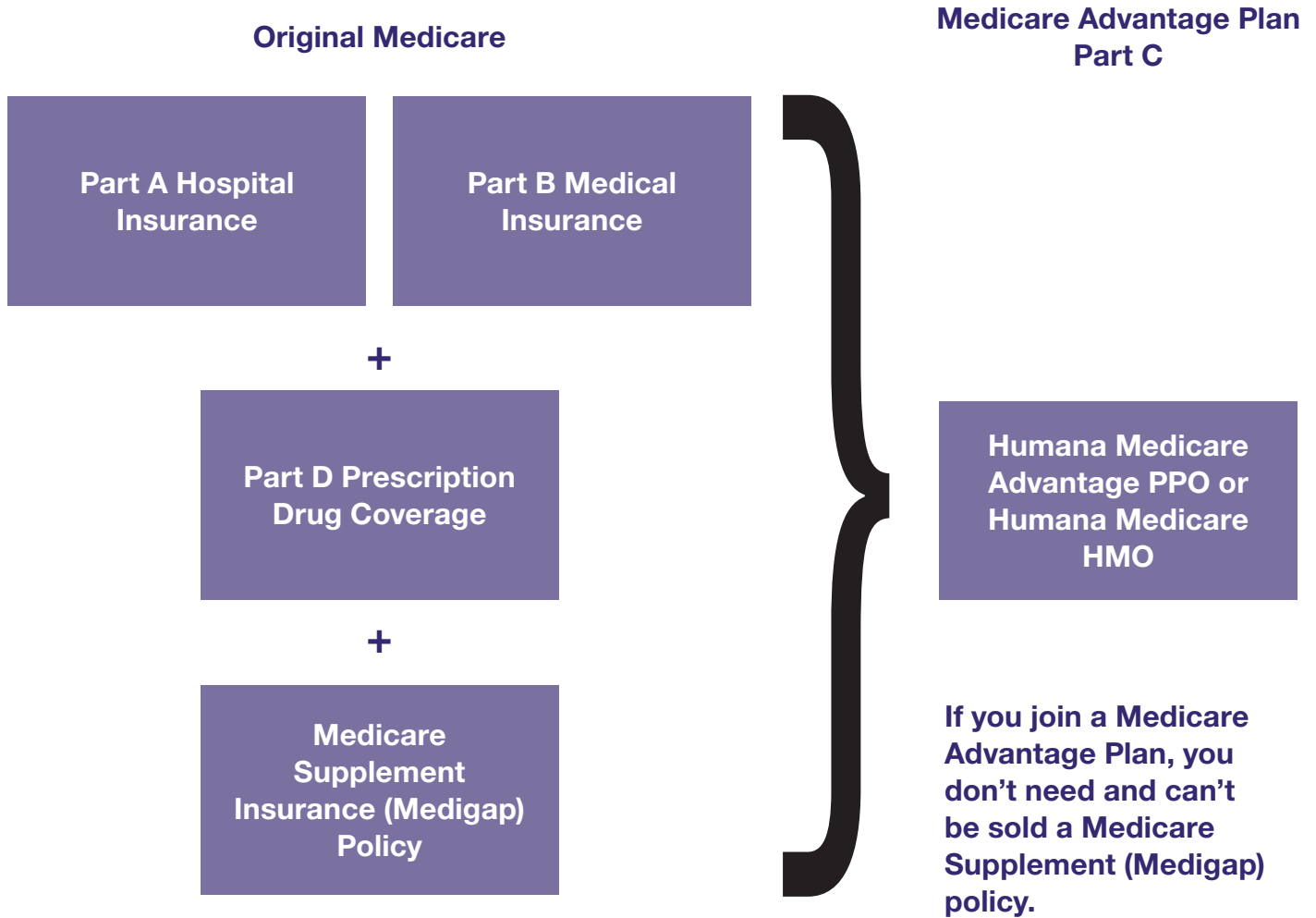
* **NOTE:** Because Sara and Mark paid their deductibles, the family deductible reached \$780, so Julie would not have to pay anything to satisfy the family deductible.

In total, the Plan would pay \$3,573, and Sara's family would pay \$1,177 (family deductible plus 10%). The \$1,177 Sara's family paid would count toward their annual out-of-pocket maximum of \$7,803. If Sara's family had received services from non-network providers, their costs would have been \$780 (deductible) plus 40% of the remainder ($0.40 \times \$3,970 = \$1,588$), so Sara's family would have paid \$2,368, and the Plan would have paid \$2,382. Sara's family saved \$1,191 by using network providers.

The Medicare Medical Benefit Options

Basics of Medicare

There are two main ways to get your Medicare coverage: original Medicare or a Medicare Advantage Plan.



The CTA RHCT provides benefits through a Medicare Advantage Plan (PPO or HMO); therefore, you don't need and can't be sold a Medicare Supplement (Medigap) policy.



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Look for the CTA RHCT logo on Medicare packets—don't enroll in any other Medicare plan if you want to keep your CTA RHCT coverage!

Humana Medicare Advantage Plans with Prescription Drug Coverage

The CTA RHCT offers a Medicare Advantage PPO Plan through Humana (Humana PPO) for all Medicare-eligible participants. It also offers a Medicare Advantage HMO Plan (Humana HMO) for certain Chicagoland counties.

If you enroll or are currently enrolled in a Medicare Advantage Plan, you should not enroll for any other Medicare or Medicare supplement coverage. See pages 19 - 21 to view a summary of the benefits available under the Plan.

In addition, a prescription drug plan (PDP), administered by Humana, is included with both Humana plans. You will have one ID card for both medical and prescription drug expenses.

Initial Medicare Advantage Enrollment

You must be enrolled in Medicare Parts A and B to initially enroll for the Humana Medicare Advantage Plan. The Humana Medicare Advantage Plan includes coverage under Medicare Parts A, B and D, and additional benefits not covered by original Medicare. Once you enroll in one of the Humana Medicare Advantage Plans, it will be your Medicare plan, **not** the original Medicare Parts A and B plan.

Humana Medicare Advantage Preferred Provider Networks

Humana's Medicare Advantage PPO network allows you to take advantage of lower, negotiated rates charged by network providers. Whether you receive care from a preferred provider or any provider who accepts Medicare, you will pay the same coinsurance or copayment. However, because preferred providers have agreed to offer their services at discounted rates, you and the Plan will save money when you use preferred providers. See the examples on page 22.

Humana Medicare HMO with Prescription Drug Coverage

The Humana Medicare Advantage HMO is only available in the following Chicagoland counties: Cook, DuPage, Kane, Kendall, Lake, McHenry and Will.

The Humana HMO provides the same benefits as the in-network benefits under the Humana PPO, though your contributions under the Humana HMO are lower. The HMO network may be slightly different from the PPO network; if you would like to enroll in the HMO, check with Humana or your doctors to ensure they are in the HMO network. Visit [humana.com/ctarhct](https://www.humana.com/ctarhct), and click **Provider Search** at the bottom of the page. Complete the information requested (the network is "Gold Plus HMO/Employer HMO IL"). The Humana HMO does not pay benefits for care received from non-network providers, except in cases of emergency.



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Humana HMO or PPO: Determining Which Is Right for You

Here are some things to consider when deciding whether to enroll in the Humana HMO or PPO option. **The Humana Medicare HMO Plan is only available if you live in the following Illinois counties: Cook, DuPage, Kane, Kendall, Lake, McHenry and Will.**

| Plan Type | YOU MAY WISH TO CHOOSE THIS PLAN IF... |
|-----------|---|
| HMO | <ul style="list-style-type: none"> • You see your primary care physician (PCP) often; under the HMO, PCP visits are covered 100%. • You do not plan to receive services from non-network providers. • You are willing to trade the flexibility of seeing any provider you wish for lower contributions. • Your current providers participate in the Humana HMO network. |
| PPO | <ul style="list-style-type: none"> • You and/or your dependents need care from non-network providers. • You are willing to pay higher monthly contributions for the ability to choose any provider and receive benefits from the Plan. |

Prescription Drug Coverage

Prescription drug benefits are provided under the PPO and HMO plans.

DO NOT ENROLL in another Medicare prescription drug plan; doing so will cancel your eligibility for the medical and prescription drug benefits through this Plan.

Assistance Paying for Prescription Drugs

If your income is limited, you may be able to receive assistance with your prescription drug costs through Social Security’s Extra Help program.

This program could pay for 75% or more of your drug costs. Additionally, if you qualify for assistance, you will not have a coverage gap or a late enrollment penalty.

For more information and to determine if you qualify for this program, contact your local Social Security office, or call Social Security at 800.772.1213 (TTY: 800.325.0778). Or apply for Extra Help online: [socialsecurity.gov/prescriptionhelp](https://www.socialsecurity.gov/prescriptionhelp).

Alternate Languages and/or Formats

To receive prescription drug information in an alternate language and/or format, such as Spanish, Braille, audio tape or large print, please contact Humana Customer Care: 800.542.2070 (TTY: 711), Monday - Friday, 7 a.m. - 7 p.m. Central Time.

Esta información está disponible en un formato diferente, incluyendo en español, en letras grandes, en Braille y en cinta de audio. Llame a la oficina de Servicio al Cliente a los números indicados arriba si necesita información sobre el plan en otro formato o en otro idioma.



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Comparison Chart

| | HUMANA MEDICARE HMO PLAN (Out-of-network services are NOT covered, except emergency care) | HUMANA MEDICARE ADVANTAGE PPO PLAN (All Medicare providers) |
|--|--|--|
| | IN-NETWORK ONLY | |
| Individual Annual Deductible | \$390 | \$390 |
| Individual Annual Out-of-Pocket Maximum | \$3,901 | \$3,901 |
| Out-of-pocket limit does not apply to contributions, extra services and prescription drugs. | | |
| OUTPATIENT SERVICES | | |
| Primary Care Physician Office Visits | Covered 100% For all care completed within a PCP's office | 90% |
| Physician Office Visits <ul style="list-style-type: none"> • Specialist • Surgery, Allergy | 90% | 90% |
| Diagnostic Services (lab tests and x-rays) | 90% | 90% |
| Outpatient Surgery | 90% | 90% |
| Annual Routine Physical Examinations | Covered 100% | Covered 100% |
| Preventive Injections and Immunizations | Covered 100% | Covered 100% |
| Routine Annual Eye Exams | Covered 100% | Covered 100% |
| Routine Annual Hearing Exams | Covered 100% | Covered 100% |

The Humana Medicare HMO Plan is only available in these Illinois counties: Cook, DuPage, Kane, Kendall, Lake, McHenry and Will.



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| | HUMANA MEDICARE HMO PLAN (Out-of-network services are NOT covered, except emergency care) | HUMANA MEDICARE ADVANTAGE PPO PLAN (All Medicare providers) |
|--|--|--|
| | IN-NETWORK ONLY | |
| HOSPITAL INPATIENT SERVICES | | |
| Limit on Days | Unlimited | Unlimited |
| Hospital Expenses | \$200 per day copayment for days 1 - 7 | \$200 per day copayment for days 1 - 7 |
| Surgery and Anesthesia | Covered 100% | Covered 100% |
| Doctor and Specialist Services | Covered 100% | Covered 100% |
| EMERGENCY SERVICES | | |
| Urgently Needed Care | Covered 100% after \$50 copayment | Covered 100% after \$50 copayment |
| Emergency Room (worldwide; waived if admitted within 48 hours) | Covered 100% after \$65 copayment | Covered 100% after \$65 copayment |
| Ambulance | 90% | 90% |
| BEHAVIORAL HEALTH SERVICES | | |
| Mental Health or Chemical Dependency: Inpatient | Covered 100% | Covered 100% |
| Mental Health or Chemical Dependency: Outpatient | 90% | 90% |
| OTHER SERVICES | | |
| Skilled Nursing Facility | Covered 100% for days 1 - 20; 90% for days 21 - 100 (maximum period) | Covered 100% for days 1 - 20; 90% for days 21 - 100 (maximum period) |
| Home Health Care | Covered 100% | Covered 100% |
| Physical Therapy | 90% | 90% |
| Podiatry Services | 90% | 90% |
| Diabetic Supplies | Covered 100% for strips, lancets and glucometer | Covered 100% for strips, lancets and glucometer |
| Discount Programs | See information from Humana for a variety of special programs and discounts | |



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HUMANA MEDICARE ADVANTAGE PPO PLAN AND HUMANA MEDICARE HMO PLAN

PRESCRIPTION BENEFIT

| Generic | |
|---|--|
| Retail (each 30-day supply, up to 90 days) | \$5 copayment |
| Mail Order (1 up-to-90-day supply) | \$10 copayment |
| | |
| Retail (each 30-day supply, up to 90 days) | \$15 copayment |
| Mail Order (1 up-to-90-day supply) | \$31 copayment |
| Brand Name Drugs Not on the Formulary (if no generic) and Specialty Drugs | |
| Retail (each 30-day supply, up to 90 days) | \$41 copayment |
| Mail Order (1 up-to-90-day supply) | \$82 copayment |
| Once your prescription out-of-pocket costs reach \$5,100 during the calendar year: | |
| Generic and Multiple Source Drugs | 5% coinsurance, up to \$41 |
| All Other Drugs | 5% coinsurance, up to \$41 |
| Maximum per Prescription | Up to \$123 for 90-day supply at retail OR up to \$82 mail order |

**The Humana Medicare HMO Plan is only available in these Illinois counties:
 Cook, DuPage, Kane, Kendall, Lake, McHenry and Will.**



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Payment Examples

EXAMPLE 1: OUTPATIENT SERVICES (HMO—In-Network) or PPO (Any Medicare Provider)

Sam needed an outpatient hospital procedure in January, and the procedure cost \$1,800. This was Sam's first medical expense during the year. Here is how the Plan paid:

| | |
|---|---------------|
| Covered expense | \$1,800 |
| Sam's deductible | -390 |
| Sam's copayment | -0 |
| Remaining expense | \$1,410 |
| Plan pays 90% | <u>-1,269</u> |
| Sam pays 10% | \$141 |
| Sam's Total Cost (\$390 + \$141) | \$531 |

EXAMPLE 2: INPATIENT SERVICES (HMO—In-Network) or PPO (Any Medicare Provider)

Jane had a hospital bill as the first expense of the year. The hospital bill was for \$10,000 for the three-day stay. Here is how the Plan paid.

| | |
|---|---------------|
| Covered expense | \$10,000 |
| Jane's deductible | -390 |
| Jane's copayment (\$200 per day for 3 days) | <u>-600</u> |
| Remaining expenses | \$9,010 |
| Plan pays 100% | <u>-9,010</u> |
| Jane pays 0% | \$0 |
| Jane's Total Cost (\$390 + \$600) | \$990 |

EXAMPLE 3: OFFICE VISIT PPO (Any Medicare Provider)

Henry met his deductible for the year. Here is how the Medicare Advantage PPO Plan would pay for an office visit if Henry used a preferred provider and if he used a non-preferred provider.

| Preferred Provider | | Non-Preferred Provider | |
|--|---------------|--|-------------|
| Covered expense (negotiated rate) | \$85.00 | Medicare-allowable amount | \$100 |
| Henry's deductible (previously met) | -0.00 | Henry's deductible (previously met) | -0 |
| Henry's copayment | <u>-0.00</u> | Henry's copayment | <u>-0</u> |
| Remaining expense | \$85.00 | Remaining expense | \$100 |
| Plan pays 90% | <u>-76.50</u> | Plan pays 90% | <u>-90</u> |
| Henry pays 10% | \$8.50 | Henry pays 10% | \$10 |
| Henry's Total Cost (\$0 + \$8.50) | \$8.50 | Henry's Total Cost (\$0 + \$10) | \$10 |



RETIREE HEALTH BENEFITS ENROLLMENT GUIDE for coverage from January 1, 2022, through December 31, 2022

Determining Your Monthly Contribution for Medical Coverage

In addition to choosing a medical plan option, there are two factors to consider when determining your monthly contribution for medical coverage.

Years of Premium Service

Your monthly contribution for medical coverage depends on how many years of premium service you—or the retiree, if you are the surviving spouse—accrued with the CTA before retiring. The longer the premium service, the lower the monthly contribution. The years of premium service category is shown on your enclosed 2021 Statement of Benefits.

Write your premium years of service here: _____

The Coverage Level You Can Elect

If you are a retiree or surviving spouse, you can elect single coverage or family coverage. Family coverage includes spouse only, dependent children only, or spouse plus dependent children. Surviving spouse coverage includes dependent children. **You must enroll ALL non-Medicare family members in the same non-Medicare plan and ALL Medicare family members in the same Medicare plan.**

Determining Your Monthly Contribution for Medical Coverage

There are three coverage levels: Retiree Only, Family, and Surviving Spouse (contribution includes dependent children).

Here's how to determine your monthly contribution for medical coverage:

1. Find the table that includes your coverage, on pages 25 - 27:
 - **Table I:** Non-Medicare only—retiree only or family
 - **Table II:** Medicare only—retiree, surviving spouse, and all family eligible for Medicare
 - **Table III:** Retiree on Medicare; at least one dependent not Medicare-eligible
 - **Table IV:** At least one dependent Medicare-eligible; retiree not Medicare-eligible
 - **Table V:** Surviving spouse and any dependent child
2. **Identify your years of premium service in the far-left column.** Your Years of Premium Service category is shown on your enclosed 2021 Statement of Benefits.



RETIREE HEALTH BENEFITS ENROLLMENT GUIDE

for coverage from January 1, 2022, through December 31, 2022

- 3. Find the column for the medical plan option in which you want to enroll.** If you want to enroll in the PPO plan, for example, your contribution for medical coverage will be under the column labeled “PPO.” If you do not know which plan you want to enroll in, use the table to compare the monthly contributions, if that will be a factor in your decision.
- 4. Circle the monthly contribution for the plan you have selected.** Write that amount in the space provided in the **Determining Your Total Monthly Contribution** section on page 32.



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2022 Monthly Contributions

The following tables will help determine your monthly contribution. See page 23 to determine which table to use. Please note that the Humana HMO is only available to people who live in the following Illinois counties: Cook, DuPage, Kane, Kendall, Lake, McHenry and Will.

| Table I | NON-MEDICARE ONLY | | | |
|------------------------------------|-------------------|----------|----------|----------|
| Retiree's Years of Premium Service | RETIREE ONLY | | FAMILY | |
| | BCBS HMO | BCBS PPO | BCBS HMO | BCBS PPO |
| 45 or more years | \$42 | \$51 | \$84 | \$102 |
| 40 to less than 45 years | \$42 | \$51 | \$184 | \$223 |
| 35 to less than 40 years | \$42 | \$51 | \$334 | \$406 |
| 30 to less than 35 years | \$68 | \$80 | \$469 | \$568 |
| 25 to less than 30 years | \$189 | \$207 | \$730 | \$868 |
| 20 to less than 25 years | \$444 | \$485 | \$1,135 | \$1,241 |
| 15 to less than 20 years | \$740 | \$810 | \$1,480 | \$1,620 |
| 10 to less than 15 years | \$838 | \$918 | \$1,676 | \$1,836 |
| Less than 10 years | \$987 | \$1,080 | \$1,974 | \$2,160 |

| Table II | MEDICARE ONLY | | | |
|------------------------------------|---------------|------------|------------|------------|
| Retiree's Years of Premium Service | RETIREE ONLY | | FAMILY | |
| | Humana HMO | Humana PPO | Humana HMO | Humana PPO |
| 45 or more years | \$6 | \$11 | \$12 | \$22 |
| 40 to less than 45 years | \$6 | \$11 | \$26 | \$49 |
| 35 to less than 40 years | \$6 | \$11 | \$49 | \$90 |
| 30 to less than 35 years | \$12 | \$21 | \$71 | \$130 |
| 25 to less than 30 years | \$29 | \$52 | \$106 | \$194 |
| 20 to less than 25 years | \$55 | \$100 | \$138 | \$255 |
| 15 to less than 20 years | \$91 | \$167 | \$182 | \$334 |
| 10 to less than 15 years | \$100 | \$184 | \$200 | \$368 |
| Less than 10 years | \$109 | \$207 | \$218 | \$414 |



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| Table III | FAMILY COMBINED: MEDICARE RETIREE, PLUS ANY DEPENDENT(S) NOT ON MEDICARE | | | |
|------------------------------------|---|----------|------------|----------|
| Medicare Retiree and Dependents = | HUMANA HMO | | HUMANA PPO | |
| Non-Medicare Dependents = | BCBS HMO | BCBS PPO | BCBS HMO | BCBS PPO |
| Retiree's Years of Premium Service | | | | |
| 45 or more years | \$48 | \$57 | \$53 | \$62 |
| 40 to less than 45 years | \$148 | \$178 | \$153 | \$183 |
| 35 to less than 40 years | \$298 | \$361 | \$303 | \$366 |
| 30 to less than 35 years | \$413 | \$500 | \$422 | \$509 |
| 25 to less than 30 years | \$570 | \$690 | \$593 | \$713 |
| 20 to less than 25 years | \$746 | \$811 | \$791 | \$856 |
| 15 to less than 20 years | \$831 | \$901 | \$907 | \$977 |
| 10 to less than 15 years | \$938 | \$1,018 | \$1,022 | \$1,102 |
| Less than 10 years | \$1,096 | \$1,189 | \$1,194 | \$1,287 |

| Table IV | FAMILY COMBINED: RETIREE NOT ON MEDICARE AND DEPENDENT(S) ON MEDICARE | | | |
|---------------------------------------|--|------------|------------|------------|
| Non-Medicare Retiree and Dependents = | BCBS HMO | | BCBS PPO | |
| Medicare Dependents = | Humana HMO | Humana PPO | Humana HMO | Humana PPO |
| Retiree's Years of Premium Service | | | | |
| 45 or more years | \$48 | \$53 | \$57 | \$62 |
| 40 to less than 45 years | \$62 | \$80 | \$71 | \$89 |
| 35 to less than 40 years | \$85 | \$121 | \$94 | \$130 |
| 30 to less than 35 years | \$127 | \$177 | \$139 | \$189 |
| 25 to less than 30 years | \$266 | \$331 | \$284 | \$349 |
| 20 to less than 25 years | \$527 | \$599 | \$568 | \$640 |
| 15 to less than 20 years | \$831 | \$907 | \$901 | \$977 |
| 10 to less than 15 years | \$938 | \$1,022 | \$1,018 | \$1,102 |
| Less than 10 years | \$1,096 | \$1,194 | \$1,189 | \$1,287 |



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| Table V Retiree's Years of Premium Service | SPOUSE AND DEPENDENT NOT MEDICARE-ELIGIBLE | | SPOUSE AND DEPENDENT MEDICARE-ELIGIBLE | |
|---|--|----------|--|------------|
| | BCBS HMO | BCBS PPO | Humana HMO | Humana PPO |
| 45 or more years | \$42 | \$51 | \$6 | \$11 |
| 40 to less than 45 years | \$142 | \$172 | \$20 | \$38 |
| 35 to less than 40 years | \$292 | \$355 | \$43 | \$79 |
| 30 to less than 35 years | \$401 | \$488 | \$59 | \$109 |
| 25 to less than 30 years | \$541 | \$661 | \$77 | \$142 |
| 20 to less than 25 years | \$691 | \$756 | \$83 | \$155 |
| 15 to less than 20 years | \$740 | \$810 | \$91 | \$167 |
| 10 to less than 15 years | \$838 | \$918 | \$100 | \$184 |
| Less than 10 years | \$987 | \$1,080 | \$109 | \$207 |

* If, as a surviving spouse, you or any of your dependents are not eligible for Medicare, you will pay the non-Medicare surviving spouse monthly contribution.

Your Medicare Part B Premiums

The Humana Medicare Advantage plans provide Medicare benefits and include Medicare Part B; however, you must continue to pay your Part B premium in addition to the Plan contributions shown on these pages. The Medicare Part B premium is typically deducted from your monthly Social Security benefit check.



The Dental Option

Dental Option Highlights

MetLife is your dental benefit provider. To determine if your current dentist participates in their network, please call 800.942.0854, or visit [metlife.com/mybenefits](https://www.metlife.com/mybenefits).

You may choose dental coverage before and after you turn age 65. When you reach age 65, you will have a 31-day application period in which to elect coverage. If you do not elect coverage within the 31 days, you may still elect coverage later, but you must wait until an open enrollment period. If you are a surviving spouse who is age 65 or older, you can only enroll within the 31-day application period. **If a retiree is under age 65, his or her spouse may continue coverage, regardless of his or her age.**

You can reduce your out-of-pocket expenses by using a PPO network dentist. See page 29 for the dental benefits summary. If you are at least age 65, you can choose the Low Over-65 Plan or the High Over-65 Plan. (See page 30 for a comparison.)

Your Monthly Contribution for Dental Coverage

Your monthly contribution for dental coverage from January 1, 2022, through December 31, 2022, is as follows:

| Coverage | Pre-65 Plan | Low Over-65 Plan | High Over-65 Plan |
|----------------------|-------------|------------------|-------------------|
| One Person | \$39.78 | \$17.34 | \$38.17 |
| Two People | \$79.45 | \$33.64 | \$74.48 |
| Three or More People | \$116.59 | \$49.16 | \$102.04 |

Network Providers

MetLife has contracted with providers to charge lower, negotiated fees for their services. The lower fees mean that you and the Plan save money when you visit network providers. The Plan pays the same coinsurance whether you go to a network provider or an out-of-network provider, but your coinsurance percentage is based on a lower cost for the service.



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Dental Plan Design Summary—Under Age 65 Plan

| COINSURANCE LEVEL EQUIVALENTS | BENEFIT LEVELS |
|--|---|
| Annual Deductible (per person) | \$25 |
| Annual Deductible (per family) | \$50 |
| Annual Maximum Benefit (per person) | \$2,000 per calendar year |
| Type A Expenses | 100% |
| Type B Expenses | 90% |
| Type C Expenses | 50% |
| TYPE A EXPENSES | |
| Exams and Prophylaxis | Covered 100%, up to 2 times per calendar year |
| Fluoride Treatments Under Age 14 | Covered 100%, up to 2 times per calendar year |
| Palliative Treatment, Sealants, Space Maintainer | Covered 100% after deductible |
| TYPE B EXPENSES | |
| Full Mouth X-Rays | 90%, once every 36 months |
| Bitewing X-Rays | 90%, once every 12 months |
| Fillings | 90% after deductible |
| Extractions | 90% after deductible |
| Other Oral Surgery | 90% after deductible |
| Anesthesia | 90% after deductible |
| Endodontics | 90% after deductible |
| Periodontics: Perio Maintenance | 90%, 2 per year combined with prophylaxis |
| Periodontics: Scaling and Root Planing | 90%, once in 18 months |
| Occlusal Guards | 90%, after deductible |
| TYPE C EXPENSES | |
| Periodontics: Surgery | 50%, once in 36 months |
| Prosthodontics | 50%, once in 5 calendar years |
| Crowns, Inlays, Onlays | 50%, once in 5 calendar years |
| Implants | 50%, once in 10 calendar years |
| Bridges | 50%, once in 5 calendar years |



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Dental Plan Design Summary—Over Age 65 Plans

| COINSURANCE LEVEL EQUIVALENTS | HIGH PLAN BENEFIT LEVELS | LOW PLAN BENEFIT LEVELS |
|---|--|-------------------------|
| Deductible (per person) | \$75 | \$75 |
| Deductible (per family) | \$225 | \$225 |
| Annual Maximum Benefit (per person) | \$1,500 per calendar year | \$750 per calendar year |
| Type A Expenses | 100% | 100% |
| Type B Expenses | 70% | 70% |
| Type C Expenses | 50% | 0% |
| TYPE A EXPENSES: Paid at 100% | | |
| Exams and Prophylaxis | Once every 6 months | |
| Fluoride Treatments – Under Age 14 | 2 every 12 months | |
| Full Mouth X-Rays | Once every 60 months | |
| Bitewing X-Rays – Under Age 19 | Once every 6 months | |
| Bitewing X-Rays – Age 19 and Older | Once per calendar year | |
| TYPE B EXPENSES: Paid at 70%, after deductible | | |
| Sealants – Up to Age 14 | Once in 60 months for each 1st and 2nd molar | |
| Palliative Treatment | 70% after deductible | |
| Space Maintainer | Once per tooth area in a lifetime for children under age 14 only | |
| Fillings (replacement) | Once in 24 months | |
| Periodontics: Perio Maintenance | 4 per year combined with prophylaxis | |



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| COINSURANCE LEVEL EQUIVALENTS | HIGH PLAN BENEFIT LEVELS | LOW PLAN BENEFIT LEVELS |
|---|--|-------------------------|
| TYPE C EXPENSES: Paid at 50%, after deductible in High Plan only | | |
| Endodontics (per tooth) | Once in 24 months | Not covered |
| Anesthesia | 50%, after deductible | Not covered |
| Periodontics Scaling and Root Planing (per quadrant) | Once every 24 months | Not covered |
| Periodontics: Surgery (per quadrant) | Once in 36 months | Not covered |
| Simple and Surgical Extractions | 50% after deductible | Not covered |
| All Other Oral Surgery | 50% after deductible | Not covered |
| Crowns, Inlays, Onlays (replacement) | Once in 10 calendar years | Not covered |
| Prosthodontics | Once in 10 calendar years | Not covered |
| Implants | Once in 10 calendar years | Not covered |
| Bridges (replacement) | Once in 10 calendar years | Not covered |
| Additional Frequency Limitations | | |
| COINSURANCE LEVEL EQUIVALENTS | HIGH PLAN BENEFIT LEVELS | LOW PLAN BENEFIT LEVELS |
| Consultations | Once in 12 months | Not covered |
| Scaling and Root Planing | 1 per quadrant in any 24-month period | Not covered |
| Repairs | Once in 12 months | Not covered |
| Recementations | Once in 12 months | Not covered |
| Dentures | 1 in 10 calendar years | Not covered |
| Dentures: Rebases and Relines | 1 in 36 months | Not covered |
| Denture Adjustments | 1 in 12 months | Not covered |
| Implant Repairs | Once per tooth in 12 months | Not covered |
| Implant Supported Prosthetic | 1 per tooth in 10 calendar years | Not covered |
| Tissue Conditioning | 1 in 36 months | Not covered |



Enrolling for Coverage: Determining Your Total Monthly Contribution

Your monthly contribution will be the medical contribution added to the dental contribution (if you enroll for dental coverage). To determine your monthly medical contribution, go to page 23, which guides you to the appropriate page for your contribution. Follow the instructions on that page, and write down the monthly cost for the medical coverage you want next to **Medical Contribution**, below. If you are choosing dental coverage, go to page 28, and write the monthly contribution for the dental coverage you want next to **Dental Contribution**, below. Add the two amounts to determine your total monthly contribution.

| | |
|---|----------|
| Medical Contribution | \$ _____ |
| Dental Contribution | \$ _____ |
| Total Monthly Contribution | \$ _____ |
| (Medical Contribution + Dental Contribution) | |

If you are changing your coverage or enrolled dependents, return your completed enrollment form in the envelope provided, postmarked by November 12, 2021. Do not send money with the form.

Completing the Enrollment Form

To keep the coverage and dependents as listed on your enclosed 2021 Statement of Benefits, there is nothing you need to do; do not return an enrollment form.

To make changes to your current coverage or to change your enrolled dependents, you must return the enclosed, completed enrollment form, postmarked by November 12, 2021. Please follow the enrollment form instructions carefully.

- 1. Complete all items in the *Participant Information* section on page 1.**
Include your Medicare information, if you have it. **Include your telephone number(s) and/or email address so you can be contacted if there are problems with or questions about your form.**
- 2. Complete all items in the *Dependent Information* section on page 2.**
Include each dependent's relationship to you, his or her date of birth, and his or her Social Security number. Include all dependent Medicare information, as applicable. **Each eligible person you are enrolling in Medicare for the first time must complete the questionnaire and sign the form.**
- 3. Indicate whether you are declining or electing medical coverage on page 4.** If you are electing medical coverage, indicate the plan option and the level of coverage you want.
- 4. Indicate whether you are declining or electing dental coverage on page 5.** If you are electing dental coverage, indicate the type of coverage you want.
- 5. Sign the *Authorization, Certification, and Agreement* on page 6.**



RETIREE HEALTH BENEFITS ENROLLMENT GUIDE for coverage from January 1, 2022, through December 31, 2022

Please review your confirmation statement carefully when you receive it. If everything looks fine, there's nothing to do. However, if there are any discrepancies, you must notify Group Administrators by December 31, 2021.

After You Enroll

Confirmation Statement

In December, you will receive a statement confirming your medical and dental plan enrollment for coverage starting January 1, 2022. The statement information will depend on whether you are currently enrolled in either plan and whether your enrollment form was received by the deadline. Specifically:

If you are currently enrolled in the medical or dental plan:

- If your enrollment form was postmarked by November 12, 2021, the confirmation statement will show the coverage you selected, your enrolled dependents and your monthly contribution.
- If you did not return the enrollment form or if it was postmarked after November 12, 2021, the confirmation statement will show the coverage on your enclosed 2021 Statement of Benefits with your 2022 monthly contribution.

If you are not currently enrolled in a medical or dental plan:

- If your enrollment form was postmarked by November 12, 2021, the confirmation statement will show the coverage you selected, your enrolled dependents and your monthly contribution.
- If you did not return the enrollment form, or if it was postmarked after November 12, 2021, the confirmation statement will indicate that you are not covered under either the medical or the dental plan as of January 1, 2022. **NOTE: You must provide documentation that you had coverage under another medical plan immediately before enrolling for coverage under the CTA RHCT Plan.**

Paying for Coverage

Your total monthly contribution will be deducted from your pension check, beginning with your January 2022 pension check. If your pension check is not sufficient to pay the entire contribution, the Trust will bill you directly for the entire amount, payable to the CTA RHCT. Your first bill for January 2022 will be sent in December 2021. If you are not paying with your pension check, your first payment will be due by January 1, 2022. If you are paying with your pension check, your first payment will be deducted from your January 2022 pension check.



RETIREE HEALTH BENEFITS ENROLLMENT GUIDE

for coverage from January 1, 2022, through December 31, 2022

Medicare Advantage: Materials to Expect from Humana

If you enroll in or change your enrollment in the Medicare Advantage Plan, you will receive the following items from Humana:

- Confirmation letter to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your enrollment with Humana
- Identification cards
- Invitation to participate in a voluntary Health Risk Survey, by phone
- Plan documents, including a schedule of copayments and a provider directory
- Prescription formulary (list of covered prescription drugs)

When seeking care, you will use your Humana ID cards rather than your Medicare ID card.

NOTES

