



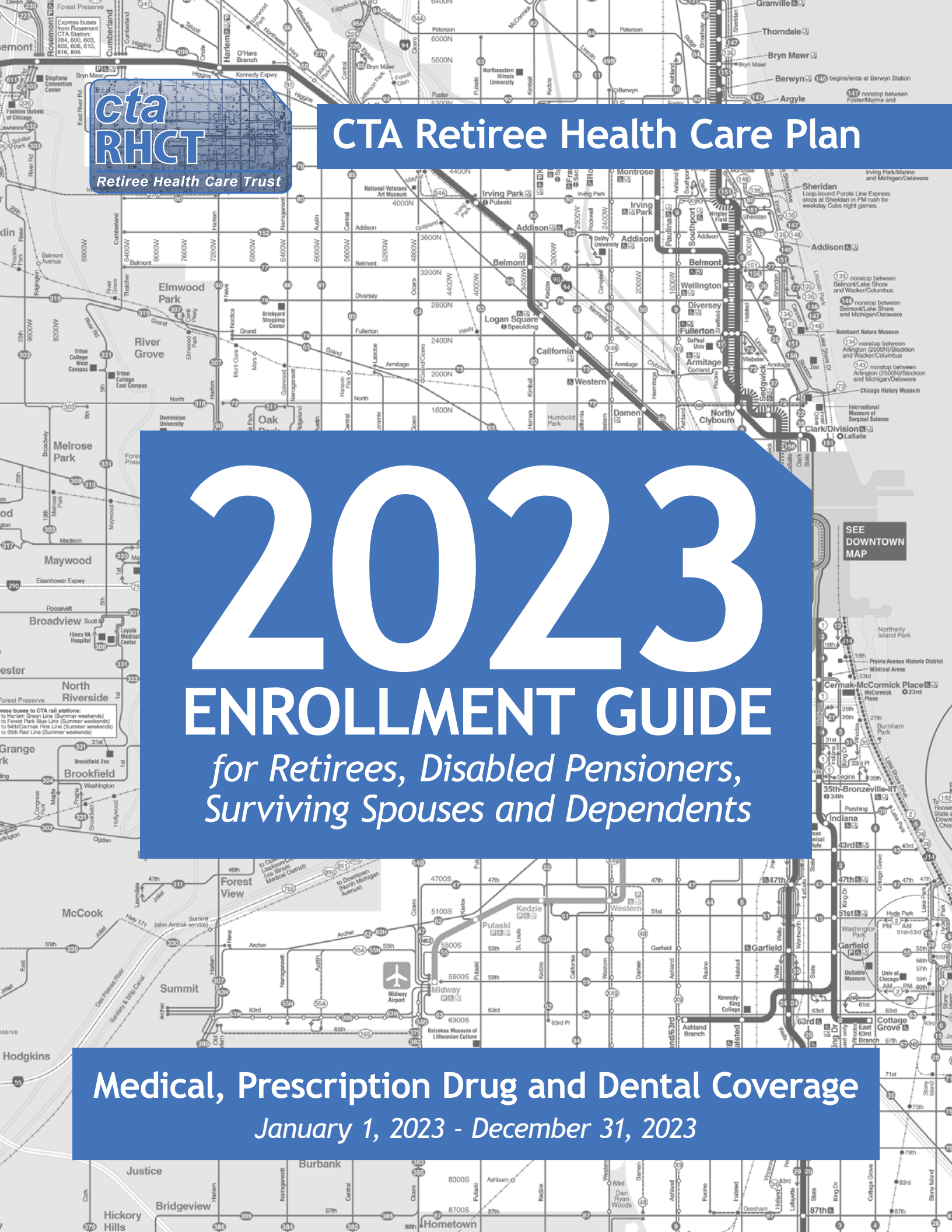
CTA Retiree Health Care Plan

2023

ENROLLMENT GUIDE

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

Medical, Prescription Drug and Dental Coverage
January 1, 2023 - December 31, 2023





RETIREE HEALTH BENEFITS ENROLLMENT GUIDE

for coverage from January 1, 2023, through December 31, 2023

Contact Information

Plan	Phone Number and Web Address
Retiree Health Care Plan Administration Group Administrators, Ltd.	Phone: 866.997.3821 Fax: 847.519.1979 groupadministrators.com
Pre-Medicare Choice Point of Service (POS) II Plan (replacement for BCBS PPO) Aetna policy # 181200	Aetna Concierge: 855.246.7404 aetna.com
Pre-Medicare Aetna Select Plan (replacement for BCBS HMO) Aetna policy # 181200	Aetna Concierge: 855.246.7404 aetna.com
CVS Caremark (prescription drugs with Aetna Choice POS II and Aetna Select)	888.797.8897 caremark.com
Aetna Discount Programs for Vision, Healthy Weight Management, Alternative Therapies and Hearing Products	Aetna Concierge: 855.246.7404 After your effective date, log onto your Aetna secure member website: myaetnawebsite.com
Medicare Plans Humana Medicare Advantage and Prescription Drug Plans	800.542.2070 (TTY: 711) humana.com/ctarhct
Dental Plans Cigna	800.244.6224 cigna.com
CTA Retirement Office	866.441.9694 or 312.441.9694 ctaretirement.org

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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TO CHANGE YOUR COVERAGE, YOU MUST ENROLL FOR BENEFITS BY NOVEMBER 15, 2022

**THE COVERAGE YOU CHOOSE NOW WILL REMAIN IN EFFECT
FROM JANUARY 1, 2023, THROUGH
DECEMBER 31, 2023,
SO MAKE YOUR SELECTIONS CAREFULLY**

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 15, 2022) will be effective January 1 – December 31, 2023. Your elections will stay in effect through December 31, 2023, unless you have a qualifying event, described on page 7.

About Your Plans and Costs for 2023

For 2023, the medical plan coverage will be changing from Blue Cross Blue Shield (BCBS) to Aetna. The dental plan will be changing from MetLife to Cigna. There are no increases to the premiums for the medical plan, and the dental plan rates are decreasing for 2023 for most participants.

Be sure to review all the information about the new plans in this enrollment guide carefully before making any decisions about your 2023 coverage. If you are married, please also share this guide with your spouse.

Please read the information in this guide thoroughly.

1. Review the enclosed 2022 Statement of Benefits. It shows your current elections and your current enrolled dependents.
2. If you do nothing, you will automatically be enrolled.
 - If you are currently enrolled in the BCBS PPO, you will be enrolled in the new Aetna Choice Point of Service (POS) II medical plan.
 - If you are currently enrolled in the HMO Illinois, you will be enrolled in the new Aetna Select medical plan. **You will need to select a Primary Care Physician (PCP).** To verify if your current PCP is in the Aetna Select network, visit docfind.com.
 - If you are currently enrolled in the MetLife dental plan, you will be enrolled in the new Cigna dental plan.
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.



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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 BLUE BAR applies to *non-Medicare-eligible participants*

DARK BLUE BAR applies to *Medicare-eligible participants*

Use the enclosed envelope to return your completed enrollment form. It must be postmarked by November 15, 2022.

Key things to remember:

- Your enrollment elections will be effective from January 1, 2023, through December 31, 2023.
- To make changes, you must return a completed enrollment form, and **it must be postmarked by Tuesday, November 15, 2022.**
- If you do not enroll or you miss the enrollment deadline, your current coverage as shown on the enclosed 2022 Statement of Benefits will continue until December 31, 2023. For under 65 non-Medicare-eligible participants, you will automatically be enrolled in one of the new plans based on your current enrollment.
- 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 28 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.



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, 2022, through November 15, 2022. The coverage you choose will be effective January 1, 2023, through December 31, 2023.

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, 2023. 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, 2024.



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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, 2022 – December 15, 2022 (for coverage effective January 1, 2023).
- ✓ 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 Aetna:

1. Aetna Choice Point of Service (POS) II (replacing the PPO)
2. Aetna Select (replacing the HMO)

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

Both the Aetna Choice POS II and Aetna Select plans 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 Aetna Choice POS II Option

The Aetna Choice POS II option has an extensive network of physicians and hospitals within Illinois. It includes a majority of Illinois physicians and hospitals and providers nationwide.

Under the Aetna Choice POS II, 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 Aetna 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 Aetna Choice POS II 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%.

Some services require precertification. There is no precertification requirement for in-network services. Precertification for certain types of out-of-network care must be obtained to avoid a reduction in benefits paid for that care. Precertification for hospital admissions, treatment facility admissions, convalescent facility admissions, home health care, hospice care and private duty nursing is required. You must call Aetna for authorization; failure to precertify for these out-of-network services will result in excluding \$400 per occurrence. Contact the Aetna Concierge phone number on the back of your ID card.



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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 Aetna Choice POS II option. Note: These examples assume services were received from network providers.

The Aetna Select Option

The Aetna Select option has an extensive network of physicians and hospitals within Illinois. It includes a majority of Illinois physicians and hospitals and providers nationwide.

Under the Aetna Select 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 Aetna network. Your PCP can be a general physician, family physician, internist or pediatrician. Each family member can have a different PCP. If you need to see a specialist or have a procedure, your PCP must provide a referral. The only specialists you can see without a referral on this plan are ob/gyn and behavioral health providers. The Plan will pay benefits only for care received from providers in the Aetna Select network. Otherwise, the Plan will not pay benefits (except for emergencies).

How the Aetna Select Plan Works

Most services received from an Aetna Select PCP or from an Aetna Select 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.

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 at www.caremark.com, or by calling CVS Caremark Member Services: 888.797.8897.

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



Aetna Choice POS II or Aetna Select: Which Plan Is Right for You?

Plan Type	Consider The Following:
Aetna Choice POS II	<ul style="list-style-type: none">• Are your doctors and other providers in the Aetna Choice POS II network?• 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?
Aetna Select	<ul style="list-style-type: none">• Are your doctors and other providers in the Aetna Select 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 Aetna Select network (except for emergencies)?

Prescription Drug Coverage

The Aetna Choice POS II and Aetna Select options include 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 **Comparison Chart** on page 14 summarizes the prescription drug benefits.



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Comparison Chart

	Aetna		
	Aetna Choice POS II		Aetna Select (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	\$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
Immunizations	Covered under routine physical examinations benefit		Covered 100%
Allergy Injections	100%, no deductible		Covered 100% after \$10 copayment per visit
Pediatric Care	90% after deductible	60% of eligible charges after deductible	Covered 100% after \$10 copayment per visit
CVS Walk-in Clinics (CVS Minute Clinics and Health Hubs)	100%, no deductible	Not available	Covered 100%
Eye Care Aetna Concierge: 855.246.7404 After your effective date, log onto your Aetna secure member website: myaetnawebsite.com	Aetna Vision Discount Program: Discounts on eye exams and corrective eyewear	Not available	Eye exam covered 100% after \$10 copayment



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	Aetna		
	Aetna Choice POS II		Aetna Select (In-Network Only)
	In-Network	Out-Of-Network	
EMERGENCY SERVICES			
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		Covered 100% if an emergency
HOSPITAL INPATIENT SERVICES			
Limit on Days	None		None
Hospital Inpatient 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 (up to 40 visits per calendar year)	90% after deductible	60% of eligible charges after deductible	Covered 100%
Outpatient Short-term Rehab: physical, occupational and speech therapies	90% after deductible	60% of eligible charges after deductible	Short-term covered 100% up to 60 visits per year (combined)
Infertility Treatment	Not covered	Not covered	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	Covered 100%



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	Aetna		
	Aetna Choice POS II		Aetna Select (In-Network Only)
	In-Network	Out-Of-Network	
BEHAVIORAL HEALTH SERVICES			
Mental Health: Inpatient	90% after deductible	60% of eligible charges after deductible	Covered 100%
Chemical Dependency: Inpatient	90% after deductible	60% of eligible charges, after deductible	Covered 100%
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	60% of eligible charges, after deductible	Covered 100% after \$10 copayment per visit
Prescription Drug Benefit			
<p>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 or a CVS Caremark retail pharmacy. Prescription drug benefits are administered by CVS Caremark.</p>			
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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Aetna Choice POS II Plan Examples

Aetna Choice POS II 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	-390
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 Choice POS II PPO discount (at least \$564), for a total of at least \$954.

Aetna Choice POS II 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	-390	-390	\$0*	-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%).

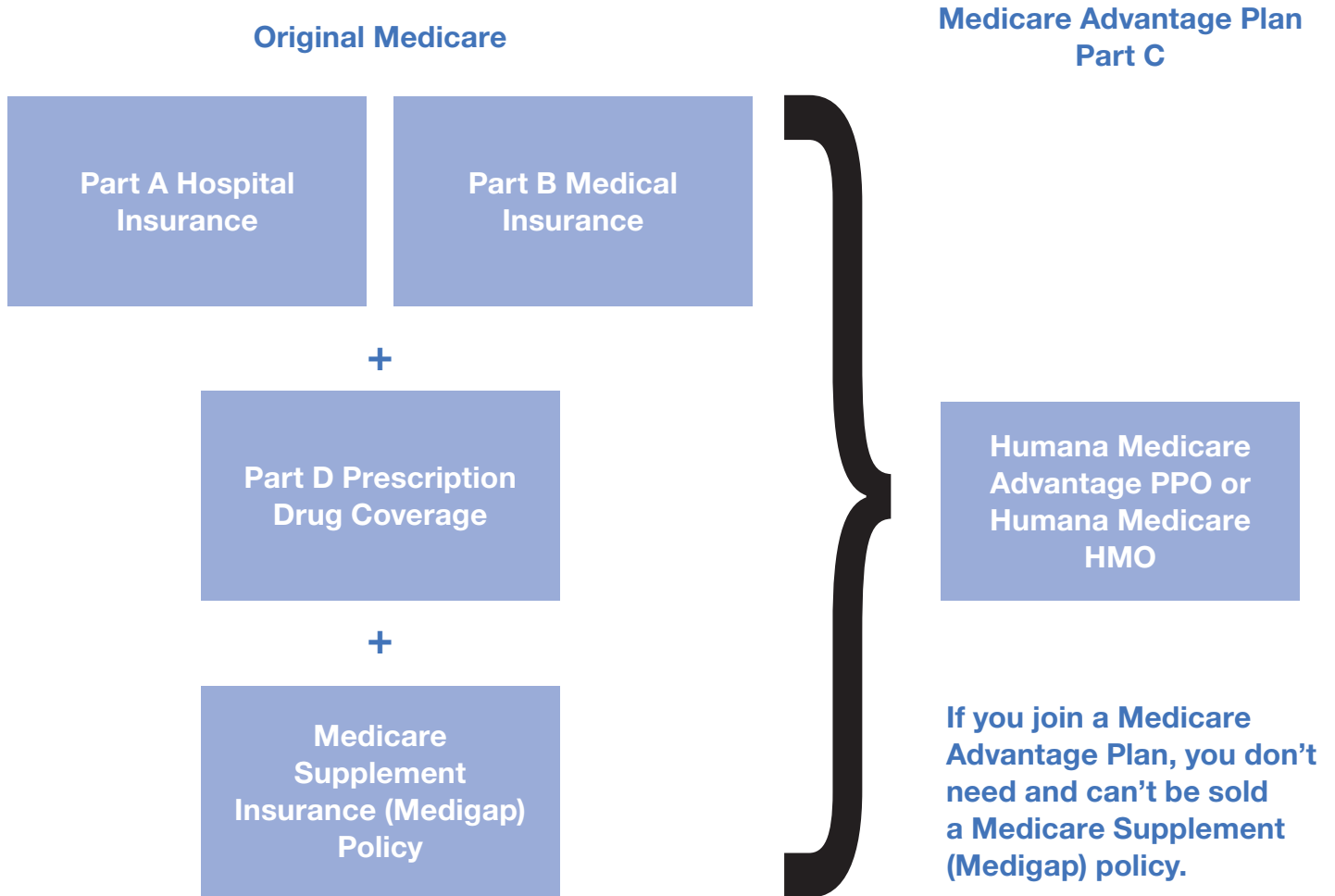
The \$1,177 Sara's family paid would count toward their annual out-of-pocket maximum of \$7,803.

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 at least \$2,368, and the Plan would have paid \$2,382. Sara's family saved at least \$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
Brand Name Drugs on the Formulary	
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%	-1,269
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)	-600
Remaining expenses	\$9,010
Plan pays 100%	-9,010
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	-0.00	Henry's copayment	-0
Remaining expense	\$85.00	Remaining expense	\$100
Plan pays 90%	-76.50	Plan pays 90%	-90
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



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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 2022 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 2022 Statement of Benefits.



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- 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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2023 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 Only		Family	
	Aetna Select	Aetna Choice POS II	Aetna Select	Aetna Choice POS II
Retiree's Years of Premium Service				
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 Only		Family	
	Humana HMO	Humana PPO	Humana HMO	Humana PPO
Retiree's Years of Premium Service				
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 =	Aetna Select	Aetna Choice POS II	Aetna Select	Aetna Choice POS II
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 =	Aetna Select		Aetna Choice POS II	
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	
	Aetna Select	Aetna Choice POS II	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

Cigna is your dental benefit provider. To determine if your current dentist participates in their network, please call 800.244.6224, or visit [cigna.com](https://www.cigna.com).

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, 2023, through December 31, 2023, is as follows:

Coverage	Pre-65 Plan	Low Over-65 Plan	High Over-65 Plan
One Person	\$28.16	\$16.03	\$23.58
Two People	\$55.09	\$31.72	\$46.18
Three or More People	\$109.09	\$66.68	\$90.52

Network Providers

Cigna 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
Class I: Diagnostic and Preventive Expenses	100%, no deductible
Class II: Basic Restorative Expenses	90%, after deductible
Class III: Major Restorative Expenses	50%, after deductible
CLASS I: DIAGNOSTIC AND PREVENTIVE EXPENSES	
Exams and Prophylaxis	100%, up to 2 times per calendar year
Fluoride Treatments – up to age 19	100%, up to 2 times per calendar year
Bitewing X-Rays	100%, up to 2 times per calendar year
Periodontic Maintenance	100%, up to 2 times per calendar year
Sealants – up to age 14	100%, limited to posterior tooth. 1 treatment per tooth every 36 months
Space Maintainers – up to age 19	100%, limited to non-orthodontic treatment
Emergency Care to Relieve Pain	100%
CLASS II: BASIC RESTORATIVE EXPENSES	
Full Mouth X-Rays	90% after deductible, once every 36 months
Fillings and Extractions	90%, after deductible
Oral Surgery: Major and Minor	90%, after deductible
Anesthesia	90%, after deductible
Endodontics: Minor and Major	90%, after deductible
Periodontics: Minor and Major	90%, after deductible
Repairs: Bridge, Crown, Inlay, and Denture	90% after deductible, reviewed if more than once
CLASS III: MAJOR RESTORATIVE AND CLASS IX: IMPLANT EXPENSES	
Crowns	50% after deductible, once in 5 years
Prosthesis Over Implant	50% after deductible, once in 5 years
Inlays and Onlays	50% after deductible, once in 5 years
Implants	50% after deductible, once in 5 years
Bridges and Dentures	50% after deductible, once in 5 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
Class I: Diagnostic and Preventive Expenses	100%, no deductible	100%, no deductible
Class II: Basic Restorative Expenses	70%, after deductible	70%, after deductible
Class III: Major Restorative Expenses	50%, after deductible	Not Covered
CLASS I: DIAGNOSTIC AND PREVENTIVE EXPENSES – Paid at 100%, No Deductible		
Exams and Prophylaxis	up to 2 times per calendar year	
Fluoride Treatments – up to age 19	up to 2 times per calendar year	
Bitewing X-Rays	up to 2 times per calendar year	
Periodontic Maintenance	up to 2 times per calendar year	
CLASS II: BASIC RESTORATIVE EXPENSES – Paid at 70%, After Deductible		
Full Mouth X-Rays	once every 36 months	
Fillings	once in 24 months	
Oral Surgery: Minor	no specific frequency limits	
Sealants – up to age 14	limited to posterior tooth, 1 treatment per tooth every 36 months	
Space Maintainers – up to age 19	limited to non-orthodontic treatment	
Emergency Care to Relieve Pain	no specific frequency limits	



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Coinsurance Level Equivalents	High Plan Benefit Levels	Low Plan Benefit Levels
CLASS III: MAJOR RESTORATIVE AND CLASS IX: IMPLANT EXPENSES – Paid at 50%, After Deductible		
Crowns	once in 5 years	not covered
Prosthesis Over Implant	once in 5 years	not covered
Inlays and Onlays	once in 5 years	not covered
Implants	once in 5 years	not covered
Bridges and Dentures	once in 5 years	not covered
Oral Surgery: Major	no specific frequency limits	not covered
Endodontics: Minor and Major	no specific frequency limits	not covered
Periodontics: Minor and Major	no specific frequency limits	not covered
Anesthesia	no specific frequency limits	not covered
Repairs: Bridge, Crown, Inlay, and Denture	reviewed if more than once	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 15, 2022. Do not send money with the form.

Completing the 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 15, 2022. 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.



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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, 2022.

After You Enroll

Confirmation Statement

In December, you will receive a statement confirming your medical and dental plan enrollment for coverage starting January 1, 2023. 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 15, 2022, 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 15, 2022, the confirmation statement will show the coverage on your enclosed 2022 Statement of Benefits with your 2023 monthly contribution.

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

- If your enrollment form was postmarked by November 15, 2022, 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 15, 2022, the confirmation statement will indicate that you are not covered under either the medical or the dental plan as of January 1, 2023. **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 2023 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 2023 will be sent in December 2022. If you are not paying with your pension check, your first payment will be due by January 1, 2023. If you are paying with your pension check, your first payment will be deducted from your January 2023 pension check.



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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

