cta RHCT
Retiree Health Care Trust

CTA RETIREE HEALTH CARE PLAN 2019 ENROLLMENT GUIDE

FOR RETIREES, DISABLED PENSIONERS, SURVIVING SPOUSES AND DEPENDENTS

Medical, Prescription Drug and Dental Coverage

from
January 1, 2019 through December 31, 2019

CONTACT INFORMATION

Plan	Phone Number and Web Address
Retiree Health Care Plan Administration Group Administrators, Ltd.	Phone:1-866-997-3821 Fax: 1-847-519-1979 www.groupadministrators.com
Pre-Medicare PPO Plan BlueCross BlueShield of Illinois (BCBSIL) PPO	1-800-292-6398 www.bcbsil.com
Wellbeing Management Enable (WBM) Program (pre-certification)	1-800-247-9204 www.bcbsil.com
CVS Caremark (prescription drugs with BCBS PPO)	1-888-797-8897 www.caremark.com
Pre-Medicare HMO Illinois Plan HMO Illinois	1-800-892-2803 www.bcbsil.com
Prime Therapeutics (prescription drugs with HMO IL)	1-800-423-1973 www.primetherapeutics.com
BCBS Blue 365 Discount Program **EyeMed Vision**	1-866-273-0813
Medicare Plans Humana Medicare Advantage and Prescription Drug Plans	1-800-542-2070 (TTY: 711) www.humana.com/ctarhct
Dental Plans MetLife	1-800-942-0854 www.metlife.com/mybenefits
CTA Retirement Office	1-866-441-9694 or 1-312-441-9694 www.ctaretirement.org

TO CHANGE YOUR COVERAGE, YOU MUST ENROLL FOR BENEFITS BY NOVEMBER 15, 2018

THE COVERAGE YOU CHOOSE NOW WILL REMAIN IN EFFECT FOR 12 MONTHS
FROM JANUARY 1, 2019 THROUGH DECEMBER 31, 2019
SO MAKE YOUR SELECTIONS CAREFULLY

Please read the information in this booklet thoroughly.

1. Review the enclosed 2018 Statement of Benefits. It shows your current elections and lists your current 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.

INTRODUCTION

The CTA Retiree Health Care Plan (the Plan) includes medical, prescription drug, and dental benefits for CTA retirees/disabled pensioners, surviving spouses and dependents. The elections you make during the open enrollment period, November 1 – November 15, will become effective on January 1, 2019. These elections will remain in effect until December 31, 2019, unless you have a qualifying event as described on page 3.

Changes for 2019

For the most part, the benefits have not changed from January 1, 2018; however, there have been a few changes, which we'd like to point out to you. The medical annual deductibles and out-of-pocket maximums, as well as some medical and prescription drug copayments, will increase on January 1, 2019. Non-Medicare and Medicare premiums have either stayed the same or decreased. Dental premiums will remain the same.

Please review all the information in this enrollment guide carefully before making any decisions. If you are married, please share the guide with your spouse. You should keep the guide in a safe place and save it for future reference.

This guide highlights some features of the medical, prescription drug, and dental plans. If a conflict arises between 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 year, the open enrollment guide includes general information that applies to everyone, information that applies to those not eligible for Medicare, and information that applies to those who are eligible for Medicare. These sections have different color bars at the top of the pages:

GRAY BAR applies to *all*

DARK RED BAR applies to *Non-Medicare* eligible participants

GOLD BAR applies to *Medicare* eligible participants

Key things to remember:

- Your enrollment elections will be effective for 12 months, from January 1, 2019 through December 31, 2019.
- If you want to make changes, you must complete your enrollment form and it must be postmarked by Thursday, November 15, 2018.
- If you do not enroll or miss the enrollment deadline, your current coverage as shown on the enclosed 2018 Statement of Benefits will continue until December 31, 2019.
- You will receive a notice in December confirming your coverage and the amount of the monthly premium you will have to pay.

Use the enclosed envelope and return your completed enrollment form – postmarked no later than November 15, 2018.

Please carefully review all of 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 2 and 4 for details.
- How the Plan's medical options work and the differences between them.
- The premiums you will have to pay for medical coverage, based on the medical option and coverage level you elect.
- The Plan's Dental options. See page 24 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 28 to complete the enrollment form.

IMPORTANT INFORMATION ABOUT THE PLAN

Eligibility

Retirees who elect health care coverage for themselves may also enroll their spouses and/or dependent children who meet the eligibility requirements.

Surviving spouses who elect health care coverage for themselves may also enroll their dependent children if the children meet the eligibility requirements.

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 prior to the date of your separation from employment with the CTA.

Eligible Dependent Children

» Any natural, adopted, 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
- Resides 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 prior to age 26, who was covered under the Plan prior to 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:
- **Birth certificate;**
- **Adoption papers;**
- **Court orders; or**
- **Armed Forces discharge papers.**

Changing Your Health Benefits

Open Enrollment

You can make changes to your benefit elections during the open enrollment period – November 1, 2018 through November 15, 2018. The coverage you choose will be effective for the calendar year January 1, 2019 through December 31, 2019.

Qualifying Event

Once you enroll, your coverage will be effective for the calendar year January 1, 2019 through December 31, 2019. During this time, you or your dependents will be allowed to change your medical elections only if you have a qualifying event. 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 that 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) becomes eligible for Medicare.
- You die. Your eligible spouse will be able to convert to surviving spouse coverage, either 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.

You or your dependent(s) must notify Group Administrators within 30 days of the qualifying event to be able to change your enrollment in the Plan. Anyone wishing to enroll in the medical plan must also provide documentation indicating he or she was covered under another medical plan immediately prior to the date he or she enrolls for coverage under this Plan.

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 as your pre-Medicare coverage under the Plan will end and you will have to 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 reside with the retiree.

If you or your dependent(s) do not have a qualifying event, you will only be allowed to change your health care elections during the next open enrollment period, for coverage effective January 1, 2020.

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 ***once*** 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 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 immediately prior (within 63 days) to 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 ACA) created healthcare exchanges or the Marketplace for anyone who wants coverage. The Marketplace provides choices in your area for healthcare coverage.

Medicare Eligible

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. Remember, you can only return to the CTA RHCT plan once in a lifetime.

Not Medicare Eligible

If you are not eligible for Medicare, you can always go to the Marketplace to compare coverage and premiums. If you find a plan that suits your family's needs better, you can buy that coverage from the Marketplace. However, if you buy coverage from the Marketplace, you will opt out of coverage from the CTA RHCT and you can only return once in your lifetime.

How Do I Shop for Coverage/Get Help?

- ✓ Marketplace Open Enrollment is November 1, 2018 – December 15, 2018 (effective January 1, 2019).
- ✓ You can go online to www.healthcare.gov and follow the prompts.
- ✓ You can also call 1-800-318-2596 (TTY: 1-855-889-4325) to speak with a representative who can help you enroll over the phone. You can also request that the representative send you a paper application.
- ✓ Online chat help (/contact-us) and telephone help is available 24/7.

THE PRE-MEDICARE MEDICAL BENEFIT OPTIONS

The Plan offers two medical options through BlueCross BlueShield (BCBS):

1. The BlueCross BlueShield of Illinois PPO (BCBSIL)
2. HMO Illinois (HMOI)

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

Both the PPO and HMO consist of a network of health care providers who have agreed to charge negotiated rates for their services. However, there are important differences between the two types of plans, which are highlighted in the sections that follow.

The PPO Option

The Plan's PPO Option is the Blue Cross Blue Shield of Illinois (BCBSIL) PPO. The BCBSIL PPO network in Illinois is extensive and includes a majority of the physicians and hospitals in Illinois.

With a PPO, you are not limited to receiving your care from a provider that participates in the PPO network. You can seek care from any doctor and/or hospital. However, because the PPO network providers have agreed to offer their services at discounted rates and non-network providers have not, both you and the Plan will 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 providers who are in the network, as discussed below.

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.

Beginning January 1, 2019, you will have to satisfy your deductibles for the 2019 calendar year and the counter for out-of-pocket maximums will start again at $0.

Once you have met the deductible for the year, the Plan will begin paying benefits for covered expenses for the person or family. In general, the Plan pays 90% for network provider expenses and 60% for non-network provider expenses. That means, when you receive services from a network provider, the Plan will pay 90% of the cost of the service, after any deductibles and/or copayments have been applied; you pay the rest, which is 10%. If you receive services from a non-network provider, the Plan will pay 60% of the cost of the services after any deductibles and/or copayments have been applied; you pay the rest, which is 40%.

Once your out-of-pocket expenses (coinsurance and 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. Deductibles and out-of-pocket maximums are based on a calendar year.

For information about deductibles, copayments, and out-of-pocket maximums, please refer to the Comparison Chart on pages 8 – 10.

Examples on page 11 illustrate how the deductibles, coinsurance percentages, and annual out-of-pocket maximums will work for both 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, through CVS Caremark. The prescription drug coverage provided under the PPO plan includes a mandatory mail-order service that is easy, convenient, and can save you money on maintenance medications. Maintenance medications are drugs you need to take on a regular basis, such as blood pressure medicine or cholesterol medicine. You are required to fill prescriptions for maintenance drug 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 will be able to ***refill it once*** at a retail pharmacy. When you get your first refill, you should 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 will have to fill this second prescription through any CVS retail store or the mail-order service.

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

Mail-order forms can be obtained from Group Administrators, online at www.caremark.com, or by calling Caremark Member Services at 1-888-797-8897.

The HMO Option

The Plan's Health Maintenance Organization (HMO) option is HMO Illinois. The HMO has an extensive network of physicians and hospitals within Illinois; however, it does not include Northwestern Memorial Hospital or physicians.

In an HMO, you choose a Primary Care Physician (PCP) for 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 network. If you need to see a specialist or have a procedure, your PCP must authorize it. The Plan will pay benefits only for providers in the HMO network. If you use a non-HMO provider, your health care expenses will not be covered, unless it is an emergency.

You will work directly with HMO Illinois to identify the Primary Care Physician (PCP) for you and each of your enrolled dependents.

How the HMO Plan Works

You may have to pay a small copayment for some services at the time of the service. For example, when you go to your PCP for an office visit, you have to pay $10 for the office visit. Most other services are paid by the Plan. When you incur expenses through an HMO provider that was authorized by your PCP, you usually pay nothing.

Prescription Drug Coverage under the HMO Option

The HMO Illinois option has a prescription drug benefit through Prime Therapeutics. The Comparison Chart on page 10 summarizes the prescription drug benefits under the HMO Illinois plan.

PPO or HMO: Determining Which Is Right for You

Here are some things to consider when deciding whether to enroll in the PPO option or the HMO option.

PLAN TYPE	YOU MAY WISH TO CONSIDER IF…
PPO	• You and/or your dependents need to be able to receive medical services outside of the State of Illinois. • Being able to choose any provider is important to you. • Your doctors and other preferred providers are in the BCBSIL PPO network. • You are willing to pay higher out-of-pocket costs when you seek medical care. • You are aware of the different deductible and coinsurance levels for network and non-network care, but feel these can work to your advantage because you intend to use mainly network providers.
HMO	• Except for emergencies, you and your dependents do not need to be able to receive medical services outside of the State of Illinois. • You are willing to trade the flexibility of being able to see any doctor you wish for increased benefits. • You do not already have an established relationship with a primary care physician or your current physician participates in the HMO network. • You do not want to have to pay deductibles or coinsurance; you would rather have to pay only small copayments at the time of service.

Comparison Chart

<table>
<tr><th rowspan="3"></th><th colspan="3">BLUE CROSS BLUE SHIELD</th></tr>
<tr><th colspan="2">PPO</th><th rowspan="2">HMOI</th></tr>
<tr><th>IN-NETWORK</th><th>OUT-OF-NETWORK</th></tr>
<tr><td>Individual Annual Deductible</td><td colspan="2">$390 individual/$780 family per calendar year</td><td>Not applicable</td></tr>
<tr><td>Lifetime Maximum</td><td colspan="2">$2,000,000 per person</td><td>Unlimited</td></tr>
<tr><td>Annual Out-of-Pocket Maximum (includes psychiatric/substance abuse)</td><td>$3,901 individual/ $7,803 family</td><td>$5,202 individual/ $10,404 family</td><td>$1,500 individual/ $3,000 family</td></tr>
<tr><td colspan="4">OUTPATIENT SERVICES</td></tr>
<tr><td>Physician Office Visits (accident or illness)</td><td>90% after deductible</td><td>60% of eligible charges, after deductible</td><td>Provided in full - $10 copayment per visit</td></tr>
<tr><td>Diagnostic Services (lab tests and x-rays)</td><td>90% after deductible</td><td>60% of eligible charges, after deductible</td><td>Provided in full</td></tr>
<tr><td>Outpatient Surgery</td><td>90% after deductible</td><td>60% of eligible charges, after deductible</td><td>Provided in full</td></tr>
<tr><td>Routine Physical Examinations</td><td colspan="2">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</td><td>Provided in full - $10 copayment per visit</td></tr>
<tr><td>Injections and Immunizations</td><td colspan="2">Covered under routine physical examination benefit</td><td>Provided in full</td></tr>
<tr><td>Pediatric Care</td><td>90% after deductible</td><td>60% of eligible charges, after deductible</td><td>Provided in full - $10 copayment per visit</td></tr>
<tr><td>Eye Care
(EyeMed Only
1-866-273-0813)</td><td>Blue 365 Discount Program: Discounts on eye exams and corrective eyewear</td><td>Not available</td><td>Eye exam paid in full after $10 copayment, $75 allowance toward pair of glasses or contact lenses every 2 years</td></tr>
<tr><td colspan="4">EMERGENCY SERVICES</td></tr>
<tr><td></td><td colspan="2">You must obtain WBM approval by calling 1-800-247-9204 within one working day if admitted. Failure to call will result in a 20% decrease in covered benefit</td><td>Primary Care Physician must be contacted except in life-threatening emergencies</td></tr>
<tr><td>Emergency Room (worldwide; waived if admitted)</td><td colspan="2">$130 copayment, waived if admitted</td><td>Provided in full after $100 copayment. Waived if admitted.</td></tr>
<tr><td>Ambulance</td><td colspan="2">90% of eligible charges, after deductible</td><td>Provided in full in an emergency or as ordered by HMO Illinois</td></tr>
</table>

	BLUE CROSS BLUE SHIELD		
	PPO		HMOI
	IN-NETWORK	OUT-OF-NETWORK	
HOSPITAL INPATIENT SERVICES			
	You must obtain WBM approval by calling 1-800-247-9204		Emergency or referral by PCP
Limit on Days	Unlimited		Unlimited
Hospital Expenses	90% after deductible	60% of eligible charges, after deductible	Provided in full - private room provided when medically necessary
Surgery and Anesthesia	90% after deductible	60% of eligible charges, after deductible	Provided in full
Doctor and Specialist Services	90% after deductible	60% of eligible charges, after deductible	Provided in full
Obstetrical Services	90% after deductible	60% of eligible charges, after deductible	Provided in full
OTHER SERVICES			
Maternity Care	90% after deductible	60% of eligible charges, after deductible	Provided in full
Skilled Nursing Care	90% after deductible	60% of eligible charges, after deductible	Provided in full
Home Healthcare or Private Duty Nurse *(Up to 40 visits per calendar year)*	90% after deductible	60% of eligible charges, after deductible	Provided in full
Physical Therapy	90% after deductible	60% of eligible charges, after deductible	Short-term therapy provided in full up to 60 visits
Family Planning	Not covered	Not covered	Diagnosis and treatment of infertility is covered
Extended Care	90% after deductible	60% of eligible charges, after deductible	Provided in full, based on medical necessity. Custodial Care is not covered.
Prosthetic Appliances & Durable Medical Equipment	90% after deductible	60% of eligible charges, after deductible	Provided in full
Transplant Services	90% after deductible	60% of eligible charges, after deductible	Contact HMOI

	BLUE CROSS BLUE SHIELD		
	PPO		HMOI
	IN-NETWORK	OUT-OF-NETWORK	
BEHAVIORAL HEALTH SERVICES			
Prior to any Mental Health or Chemical Dependency Treatment, or within one business day of any emergency admission, you must call BCBS at 1-800-292-6398.			
Mental Health - Inpatient	90% after deductible	60% of eligible charges, after deductible	Provided in full
Chemical Dependency - Inpatient	90% after deductible. No dependent coverage.	60% of eligible charges, after deductible. No dependent coverage.	Provided in full. No dependent coverage.
You must contact BCBS within one working day of an emergency admission or be subject to a 20% decrease in covered benefits.			
Mental Health - Outpatient	90% after deductible	60% of eligible charges, after deductible	$10 copayment per visit
Chemical Dependency - Outpatient	90% after deductible. No dependent coverage.	60% of eligible charges, after deductible. No dependent coverage.	$10 copayment per visit. No dependent coverage.
PRESCRIPTION BENEFIT You may use any retail pharmacy for one-time prescriptions. All maintenance prescription drugs will have a retail fill limit of 1 refill. After the first refill, you will need to fill your prescription(s) through the Mail Service Pharmacy (PPO or HMOI) or a CVS Caremark pharmacy (for PPO only - mail order discount applies). THE PRESCRIPTION DRUG BENEFITS MANAGER FOR BCBSIL PPO IS CVS CAREMARK, FOR HMOI IT IS PRIME THERAPEUTICS.			
Generic			**Generic**
Retail (30 day supply)	$13 copayment		$5 copayment
Mail Order (90 day supply)	$26 copayment		$10 copayment
Brand Name Drugs on the Formulary List (if no generic)			**Preferred**
Retail (30 day supply)	$26 copayment		$10 copayment
Mail Order (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 (30 day supply)	$65 copayment		$25 copayment
Mail Order (90 day supply)	$130 copayment		$50 copayment

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	$1,800.00
Sam's Deductible	- $390.00
Remaining Expense	$1,410.00
Plan Pays 90%	$1,269.00
Sam Pays 10%	$141.00

In total, the Plan would pay $1,269.00 and Sam would pay $531.00 (deductible plus 10%). The $531.00 Sam paid would count toward his annual out-of-pocket maximum of $3,799.

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 $564.00) for a total of at least $954.

PPO EXAMPLE 2: FAMILY COVERAGE

Sara and Sara's 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	$2,500.00	$750.00	$1,500.00	**$4,750.00**
2. Family Deductibles	- $390.00	- $390.00	$0.00*	**- $780.00**
3. Remaining Expenses	$2,110.00	$360.00	$1,500.00	**$3,970.00**
4. Plan Pays 90%	$1,899.00	$324.00	$1,350.00	**$3,573.00**
5. Sara's Family Pays 10%	$211.00	$36.00	$150.00	**$397.00**
Total Plan Pays (4)	$1,899.00	$324.00	$1,350.00	**$3,573.00**
Total Family Pays (2 + 5)	$601.00	$426.00	$150.00	**$1,177.00**

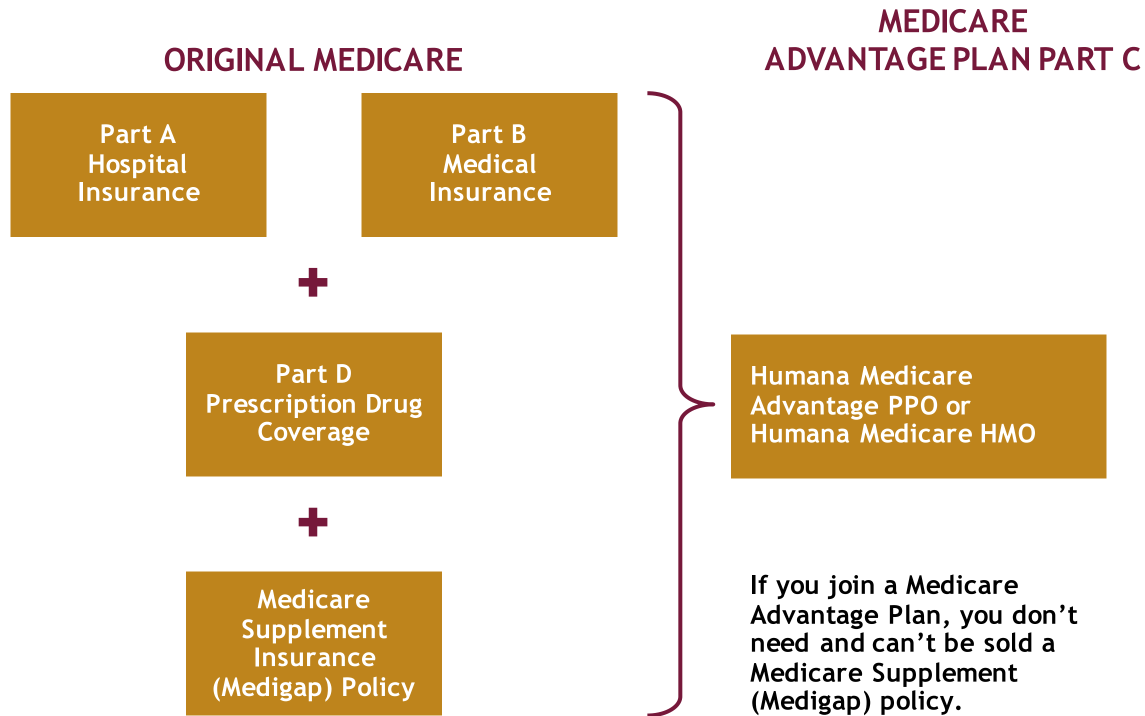
* **NOTE**: Because Sara and Mark paid their deductibles, the family deductible reached $780, Julie would not have to pay anything to satisfy the family deductible.

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 (.40 x $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.

Humana Medicare Advantage Plans with Prescription Drug Coverage

The CTA RHCT through Humana offers a Medicare Advantage PPO (Humana PPO) Plan for all Medicare-eligible participants and a Medicare Advantage HMO (Humana HMO) Plan 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 15 – 17 to view a summary of the benefits available under the Plan.

In addition, a Prescription Drug Plan (PDP) is included with the both Humana Plans. Prescription drug coverage will be provided through Humana. You will have one ID card for both medical and prescription drug expenses.

Look for the CTA RHCT logo on Medicare packets—don't enroll in any other Medicare Plan if you want to stay with CTA RHCT coverage.

Initial Medicare Advantage Enrollment

You must be enrolled in Medicare Parts A and B to initially enroll for the Humana Medicare Advantage Plan, which is a Medicare offering and includes coverage through Medicare Parts A, B, and D, as well as additional benefits not covered by traditional Medicare. Once you enroll in one of the Humana Medicare Advantage Plans, it will be your Medicare plan, not the traditional 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. Whether you go to a preferred provider or any provider who accepts Medicare, you will pay the same level of coinsurance or copayment. However, because preferred providers have agreed to offer their services at discounted rates and non-preferred providers have not, both you and the Plan will save money when you use preferred providers. See the examples on page 18.

Humana Medicare HMO with Prescription Drug Coverage

The Humana Medicare Advantage HMO is only available in these counties in the Chicagoland area: Cook, DuPage, Kane, Kendall, Lake, McHenry and Will. The Humana HMO provides the same benefits as the in-network benefits under the Humana PPO, with lower premiums. The HMO network may be slightly different than the PPO network; you should check with Humana or your doctors to ensure they are in the HMO network if you are interested in enrolling in the HMO. Go to www.humana.com/ctarhct and click on "Provider Search" at the bottom of the page. Complete the information requested (network is "Gold Plus HMO/Employer HMO IL"). The Humana HMO does not provide any out-of-network benefits, except for emergency benefits.

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 the PPO option. **The Humana Medicare HMO Plan is available if you live in Illinois counties Cook, DuPage, Kane, Kendall, Lake, McHenry and Will only.**

PLAN TYPE	YOU MAY WISH TO CONSIDER IF…
HMO	• If you see your Primary Care Physician (PCP) often, under the HMO, you have a $0 copay for PCP visits. • Except for emergencies, you and your dependents do not need to be able to receive medical services outside of these counties. • You are willing to trade the flexibility of being able to see any provider you wish for lower premiums. • Your current physicians participate in the Humana HMO network.
PPO	• You and/or your dependents need to be able to receive medical services outside of these counties. • You are willing to pay higher monthly premiums for the ability to choose any provider.

Prescription Drug Coverage

Through your enrollment in either of the Humana Medicare plans, you will receive a prescription drug benefit.

DO NOT ENROLL **in another Medicare Prescription Drug plan; doing so will cancel your eligibility for the medical and prescription benefit through this Plan.**

Assistance Paying Your Premium

People with limited incomes may be able to receive assistance with their prescription drug costs through Social Security's Extra Help program.

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

To receive more information and determine if you qualify for this program, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users may call 1-800-325-0778. You can also apply for Extra Help online at 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 at: 1-800-542-2070 (TTY: 711), Monday – Friday, 7am – 7pm, 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.

Comparison Chart

	HUMANA MEDICARE HMO PLAN (Out-of-Network services are NOT COVERED—except emergency care) IN-NETWORK ONLY	HUMANA MEDICARE ADVANTAGE PPO PLAN (All Medicare Providers)
Individual Annual Deductible	$390	$390
Individual Annual Out-of-Pocket Maximum	$3,901	$3,901
Out-of-pocket limit does not apply to Plan Premium, Extra Services, and prescription drugs.		
OUTPATIENT SERVICES		
Primary Care Physician Office Visit	100% All care completed within the PCP office is covered at 100%	90%
Physician Office Visits • Specialist • Surgery, Allergy	90%	90%
Diagnostic Services (lab tests and x-rays)	90%	90%
Outpatient Surgery	90%	90%
Annual Routine Physical Examinations	100%	100%
Preventive Injections and Immunizations	100%	100%
Routine Eye Exam - annually	100%	100%
Routine Hearing Exam - annually	100%	100%

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

	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 copay for days 1 – 7	$200 per day copay for days 1 – 7
Surgery and Anesthesia	100%	100%
Doctor and Specialist Services	100%	100%
EMERGENCY SERVICES		
Urgently Needed Care	100% after $50 copay	100% after $50 copay
Emergency Room (worldwide; waived if admitted within 48 hours)	100% after $65 copay	100% after $65 copay
Ambulance	90%	90%
BEHAVIORAL HEALTH SERVICES		
Mental Health or Chemical Dependency—Inpatient	100%	100%
Mental Health or Chemical Dependency—Outpatient	90%	90%
OTHER SERVICES		
Skilled Nursing Facility	100% for days 1-20; 90% for days 21 – 100 (maximum period)	100% for days 1-20; 90% for days 21 – 100 (maximum period)
Home Healthcare	100%	100%
Physical Therapy	90%	90%
Podiatry Services	90%	90%
Diabetic Supplies	100% for strips, lancets and glucometer	100% for strips, lancets and glucometer
Discount Programs	See the information from Humana for a variety of special programs and discounts.	

HUMANA MEDICARE ADVANTAGE PPO PLAN HUMANA MEDICARE HMO PLAN	
PRESCRIPTION BENEFIT	
Generic	
Retail (each 30-day supply, up to 90 days)	$5 copayment
Mail Order (one 90-day supply)	$10 copayment
Brand Name Drugs on the Formulary List (if no generic)	
Retail (each 30-day supply, up to 90 days)	$15 copayment
Mail Order (one 90-day supply)	$30 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 (one 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 available in Illinois counties Cook, DuPage, Kane, Kendall, Lake, McHenry and Will only.

Payment Examples: HMO (In-Network) or PPO (Any Medicare Provider)

EXAMPLE 1: OUTPATIENT SERVICES

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	$1,800.00
Sam's Deductible	- $390.00
Sam's Copay	-$0.00
Remaining Expense	$1,410.00
Plan Pays 90%	-$1,269.00
Sam Pays 10%	$141.00
Sam's Total Cost ($390.00 + $141.00)	**$531.00**

EXAMPLE 2: INPATIENT SERVICES

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

Covered Expense	$10,000
Jane's Deductible	- $390
Jane's Copay ($200 per day for 3 days)	-$600
Remaining Expenses	$9,010
Plan Pays 100%	-$9,010
Jane Pays 0%	$0
Jane's Total Cost ($390.00 + $600.00)	**$990**

EXAMPLE 3: OFFICE VISIT

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.

In-Network Provider		**Out-of-Network 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 Copay	-$0.00	Henry's Copay	-$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**

DETERMINING YOUR MONTHLY CONTRIBUTION FOR MEDICAL COVERAGE

In addition to your choice of medical plan options, there are two factors you must consider when determining the amount of your premiums:

Years of Premium Service

The cost you must pay 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 premium cost will be. The years of premium service category is shown on your enclosed 2018 Statement of Benefits.

Jot down your premium years of service here: _____________

The Coverage Level You Can Elect

If you are a retiree or surviving spouse, you can elect either single coverage or family coverage. Retiree 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 (premium includes dependent children).

The following steps will help you determine your monthly contribution for medical coverage.

1. Find the table that includes your coverage on pages 21 – 23:
   - 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 2018 Statement of Benefits.

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 rates will be under the column labeled "PPO." If you do not know which plan you want to enroll in, you can use the table to compare the monthly premium rates if that will be a factor in your decision.
4. **Circle the premium rate for the plan you have selected.** Write that amount in the space provided in the **Determining Your Total Monthly Premium Cost** section on page 28.

2019 Monthly Premiums

The following tables will help determine your monthly premium cost. See page 19 to determine which table to use. Please note that the Humana HMO is only available to people who live in the following counties in the Chicagoland area: Cook, Lake, DuPage, Will, Kane, Kendall and McHenry.

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	$43	$51	$86	$102
40 to less than 45 years	$43	$51	$189	$223
35 to less than 40 years	$43	$51	$343	$406
30 to less than 35 years	$70	$80	$482	$568
25 to less than 30 years	$245	$279	$802	$940
20 to less than 25 years	$457	$485	$1,168	$1,241
15 to less than 20 years	$761	$810	$1,522	$1,620
10 to less than 15 years	$862	$918	$1,724	$1,836
Less than 10 years	$1,015	$1,080	$2,030	$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	$7	$13	$14	$26
40 to less than 45 years	$7	$13	$30	$57
35 to less than 40 years	$7	$13	$56	$106
30 to less than 35 years	$14	$25	$81	$153
25 to less than 30 years	$40	$75	$128	$242
20 to less than 25 years	$62	$118	$157	$300
15 to less than 20 years	$103	$196	$206	$392
10 to less than 15 years	$114	$216	$228	$432
Less than 10 years	$124	$243	$248	$486

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	$50	$58	$56	$64
40 to less than 45 years	$153	$179	$159	$185
35 to less than 40 years	$307	$362	$313	$368
30 to less than 35 years	$426	$502	$437	$513
25 to less than 30 years	$597	$701	$632	$736
20 to less than 25 years	$773	$818	$829	$874
15 to less than 20 years	$864	$913	$957	$1,006
10 to less than 15 years	$976	$1,032	$1,078	$1,134
Less than 10 years	$1,139	$1,204	$1,258	$1,323

Table IV	FAMILY COMBINED - RETIREE NOT ON MEDICARE, PLUS SPOUSE AND/OR 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	$50	$56	$58	$64
40 to less than 45 years	$66	$87	$74	$95
35 to less than 40 years	$92	$136	$100	$144
30 to less than 35 years	$137	$198	$147	$208
25 to less than 30 years	$333	$412	$367	$446
20 to less than 25 years	$552	$639	$580	$667
15 to less than 20 years	$864	$957	$913	$1,006
10 to less than 15 years	$976	$1,078	$1,032	$1,134
Less than 10 years	$1,139	$1,258	$1,204	$1,323

Table V	SPOUSE AND DEPENDENT NOT MEDICARE ELIGIBLE		SPOUSE AND DEPENDENT MEDICARE ELIGIBLE	
Retiree's Years of Premium Service	BCBS HMO	BCBS PPO	Humana HMO	Humana PPO
45 or more years	$43	$51	$7	$13
40 to less than 45 years	$146	$172	$23	$44
35 to less than 40 years	$300	$355	$49	$93
30 to less than 35 years	$412	$488	$67	$128
25 to less than 30 years	$557	$661	$88	$167
20 to less than 25 years	$711	$756	$95	$182
15 to less than 20 years	$761	$810	$103	$196
10 to less than 15 years	$862	$918	$114	$216
Less than 10 years	$1,015	$1,080	$124	$243

* 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 premium rate.

Your Medicare Part B Premiums

The Humana Medicare Advantage Plans provides Medicare benefits and includes Medicare Part B; however, you must continue to pay your Part B premium in addition to the Plan premium 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 1-800-942-0854 or go to www.metlife.com/mybenefits.

You may choose dental coverage before and after you turn age 65. When you turn 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 over age 65, you can only enroll within the 31-day application period. **If a retiree is under age 65, his/her spouse may continue coverage, regardless of age.**

You can reduce your out-of-pocket expenses by utilizing a dentist that participates in the dental PPO network. See page 25 for your dental summary. If you are at least age 65, you have a choice between the Low 65 Plan and the High 65 Plan (see page 26 for a comparison).

Your Monthly Contribution for Dental Coverage

Your monthly premium cost for dental coverage from January 1, 2019 through December 31, 2019 is as follows:

Coverage/Plan	Pre-65 Plan	Low Over 65 Plan	High Over 65 Plan
One person	$40.18	$17.52	$38.56
Two people	$80.25	$33.98	$75.23
Three or more	$117.77	$49.66	$103.07

Network Providers

MetLife has contracted with providers in their network to charge negotiated fees for their services. The negotiated fees are lower than these providers would normally charge. Therefore, you save money when you go to a network provider. 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.

Note: MetLife did not raise the premiums because the Fund allowed them to send some promotional materials to you. You are under no obligation to sign up for or buy additional MetLife services.

Dental Plan Design Summary—Under Age 65 Plan

COINSURANCE LEVEL EQUIVALENTS	BENEFIT LEVELS
Deductible (per Person)	$25
Deductible (per Family)	$50
Annual Maximum Benefit (per person)	$2,000 per calendar year
TYPE A	100%
TYPE B	90%
TYPE C	50%
TYPE A	
Exams and Prophylaxis	100%, up to 2 times per calendar year
Fluoride Treatments Under Age 14	100%, up to 2 times per calendar year
Palliative Treatment, Sealants, Space Maintainer	100%, after deductible
TYPE B	
Full Mouth X-rays	Once every 36 months
Bitewing X-rays	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	2 per year combined with prophylaxis
Periodontics – Scaling/Root Planning	Once in 18 months
Occlusal Guards	90%, after deductible
TYPE C	
Periodontics - Surgery	Once in 36 months
Prosthodontics	Once in 5 calendar years
Crowns, Inlays, Onlays	Once in 5 calendar years
Implants	Once in 10 calendar years
Bridges	Once in 5 calendar years

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	100%	100%
TYPE B	70%	70%
TYPE C	50%	0%
TYPE A: Paid at 100%		
Exams and Prophylaxis	Once every six months	
Fluoride Treatments - Under Age 14	Two 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: 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	

Dental Plan Design Summary—Over Age 65 Plans *continued*

COINSURANCE LEVEL EQUIVALENTS	HIGH PLAN BENEFIT LEVELS	LOW PLAN BENEFIT LEVELS
TYPE C: 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 planning (per quadrant)	Once every 24 months	Not Covered
Periodontics – Surgery (per quadrant)	Once in 36 months	Not Covered
Simple & 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		
Consultations	Once in 12 months	
Scaling & Root Planing	One per quadrant in any 24-month period	
Repairs	Once in 12 months	
Recementations	Once in 12 months	
Dentures	One in ten calendar years	
Dentures – Rebases/Relines	One in 36 months	
Denture Adjustments	One in 12 months	
Implant Repairs	Once per tooth in 12 months	
Implant Supported Prosthetic	One per tooth in 10 calendar years	
Tissue Conditioning	One in 36 months	

ENROLLING FOR COVERAGE

Determining Your Total Monthly Premium Cost

Your monthly premium cost will be the medical premium added to the dental premium (if enrolled). To determine your monthly medical premium, go to page 19, which guides you to the appropriate page for your premium. Follow the instructions on that page and write down the monthly premium for the medical coverage you want next to ***Medical Premium*** below. If you are choosing dental coverage, go to page 24 and write the monthly premium for the dental coverage you want next to ***Dental Premium*** below. Add the two amounts to determine your total monthly premium.

Medical Premium $________________

Dental Premium $________________

Total Monthly Premium $________________ ***(Medical Premium + Dental Premium)***

Completing the Enrollment Form

If you want to keep the coverage and dependents as listed on your enclosed 2018 Statement of Benefits, **do not** send in an enrollment form. If you want to make changes to your elected coverage or dependents, you must complete the enrollment form that was included with this guide and return it in the envelope provided by November 15, 2018 (postmarked). Please follow the enrollment form instructions carefully.

If you are making changes to your elected coverage or dependents, send the enrollment form in the envelope provided by November 15, 2018. You do not need to send any money with the form.

1. **Complete the *Participant Information* section on page 1 completely.** Include your Medicare information, if you have it. Remember to include your telephone number(s) and/or email address so someone can contact you if there are any problems or questions.
2. **Complete the *Dependent Information* section on page 2 completely.** Be sure to include each dependent's relationship to you, his or her date of birth, and his or her Social Security Number. Be sure to include all dependent Medicare information as applicable. **Each person who is Medicare eligible that 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, be sure to 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, be sure to indicate the type of coverage you want.
5. **Sign the *Authorization, Certification, and Agreement* on page 6.**

AFTER YOU ENROLL

Confirmation Statement

In December, you will receive a confirmation statement that indicates your medical and dental plan enrollments effective January 1, 2019. The statement details 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 the deadline, the confirmation statement will show the coverage you selected, the list of dependents you enrolled, and your monthly premium.
- If you did not return the enrollment form, or it was postmarked after the deadline, the confirmation statement will show the coverage shown on your enclosed 2018 Statement of Benefits with your 2019 monthly premium.

Please review the confirmation statement carefully when you receive it. If there are no issues with your enrollment, you do not have to do anything. However, if there are any discrepancies, you must notify Group Administrators no later than December 31, 2018.

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

- If your enrollment form was postmarked by the deadline, the confirmation statement will show the coverage you selected, the list of dependents you enrolled, and your monthly premium.
- If you did not return the enrollment form, or it was postmarked after the deadline, the confirmation statement will indicate that you are not covered under either the medical or the dental plan as of January 1, 2019. Please keep in mind that you must provide documentation of coverage under another medical plan immediately prior to enrolling for coverage under the CTA RHCT Plan.

Paying for Coverage

Your total monthly premium will be deducted from your pension check, beginning with the January 2019 pension checks. If your pension check is not sufficient to pay the entire premium, the Trust will bill you directly for the entire amount, payable to the CTA RHCT. Your first bill for January 2019 will be sent in December 2018. If you are not paying with your pension check, your first payment will be due by January 1, 2019. If you are paying with your pension check, your first payment will be deducted from your January 2019 pension check.

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 of approval of your enrollment with Humana by CMS (Centers for Medicare and Medicaid Services)
- Identification Cards
- Invitation to participate in a voluntary Health Risk Survey (this will be a phone call)
- Plan Documents including your evidence of coverage, schedule of copayments and directory
- Prescription Formulary List

You will use your Humana cards rather than your Medicare cards when seeking care.