cta RHCT
Retiree Health Care Trust

CTA Retiree Health Care Plan

2020 ENROLLMENT GUIDE

for Retirees, Disabled Pensioners, Surviving Spouses & Dependents

Medical, Prescription Drug, and Dental Coverage

January 1, 2020 - December 31, 2020

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 PPO Plan BlueCross and BlueShield of Illinois (BCBSIL) PPO	800.292.6398 bcbsil.com
Wellbeing Management Enable (WBM) Program (pre-certification)	800.247.9204 bcbsil.com
CVS Caremark (prescription drugs with BCBS PPO)	888.797.8897 caremark.com
Pre-Medicare HMO Illinois Plan HMO Illinois	800.892.2803 bcbsil.com
Prime Therapeutics (prescription drugs with HMO IL)	800.423.1973 www.primetherapeutics.com
BCBS Blue 365 Discount Program **EyeMed Vision**	866.273.0813
Medicare Plans Humana Medicare Advantage and Prescription Drug Plans	800.542.2070 (TTY: 711) humana.com/ctarhct
Dental Plans MetLife	800.942.0854 metlife.com/mybenefits
CTA Retirement Office	866.441.9694 or 312.441.9694 ctaretirement.org

TO CHANGE YOUR COVERAGE, YOU MUST ENROLL FOR BENEFITS BY NOVEMBER 15, 2019

THE COVERAGE YOU CHOOSE NOW WILL REMAIN IN EFFECT *FROM JANUARY 1, 2020 THROUGH DECEMBER 31, 2020*, SO MAKE YOUR SELECTIONS CAREFULLY

Please read the information in this guide thoroughly.

1. Review the enclosed 2019 Statement of Benefits. It shows your current elections and your current enrolled dependents.
2. If you want to keep your current coverage, **DO NOTHING**. You do not need to re-enroll.
3. If you want to make changes, complete the enclosed enrollment form and return it to Group Administrators in the envelope provided, so it arrives by November 15.

INTRODUCTION

The CTA Retiree Health Care Plan (the Plan) includes medical, prescription drug and dental coverage for CTA retirees/disabled pensioners, surviving spouses and eligible dependents. The elections you make during open enrollment (November 1 – November 15, 2019) will be effective January 1 – December 31, 2020. Your elections will stay in effect through December 31, 2020 unless you have a qualifying event, described on page 3.

About Your Plans and Costs for 2020

Annual deductibles, copayments, annual out-of-pocket maximums and other features for all medical and dental plans will be **the same** for 2020 as they are today. Plus, the contributions for all medical and dental plans will be **the same** for 2020 as they are today.

Even though there are no medical plan or dental plan benefit coverage or contribution changes for 2020, be sure to review all the information in this enrollment guide carefully before making any decisions about your 2020 coverage. If you are married, please share this guide with your spouse.

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

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THE OPEN ENROLLMENT PROCESS

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

GRAY BAR applies to *all participants*

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

DARK BLUE BAR applies to *Medicare* eligible participants

Key things to remember:

» Your enrollment elections will be effective from January 1, 2020 through December 31, 2020.

» To make changes, you must return a completed enrollment form, and **it must be postmarked by Friday, November 15, 2019.**

» If you do not enroll or you miss the enrollment deadline, your current coverage as shown on the enclosed 2019 Statement of Benefits will continue until December 31, 2020.

» You will receive a notice in December confirming your coverage and the monthly contribution you will pay.

Use the enclosed envelope to return your completed enrollment form. It must be postmarked by November 15, 2019.

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.

» 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 25 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 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, who 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.**

Changing Your Health Benefits

Open Enrollment

You can change your benefit elections during the open enrollment period: November 1, 2019 through November 15, 2019. The coverage you choose will be effective January 1, 2020 through December 31, 2020.

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, 2020. 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, 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.

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.

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 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, 2021.

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 healthcare 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/Get Help?

- ✓ Marketplace Open Enrollment is November 1, 2019 – December 15, 2019 (for coverage effective January 1, 2020).
- ✓ 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 BlueCross and BlueShield (BCBS):

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

The PPO Option

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

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

How the PPO Option Works

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

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

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 8 – 10 for information about annual deductibles, copayments and out-of-pocket maximums.

Examples on page 11 illustrate how the deductibles, coinsurance percentages and annual out-of-pocket maximums work for individual and family coverage in the PPO option. Note: These examples assume services were received from network providers.

Prescription Drug Coverage under the PPO Option

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

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

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

The HMO Option

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

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

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

How the HMO Plan Works

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

Prescription Drug Coverage under the HMO Option

The HMO Illinois option offers prescription drug coverage administered by Prime Therapeutics. The **Comparison Chart** on page 10 summarizes the HMO Illinois drug benefits.

PPO or HMO: Which Plan is Right for You?

PLAN TYPE	CONSIDER THE FOLLOWING:
PPO	• Are your doctors and other providers in the BCBSIL PPO network? • Do you and/or your enrolled dependents need medical services from providers outside of the state of Illinois? • Is the option to choose any medical provider important to you? • Are you willing to pay more for care from non-network providers, if you need non-network care?
HMO	• Are your doctors and other providers in the HMO Illinois network? • Are you comfortable with having to get a referral from your PCP each time you need care from other network providers? • Are you OK with not receiving benefits if you see a provider outside of the HMO Illinois network (except for emergencies)?

Comparison Chart

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

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

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

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**

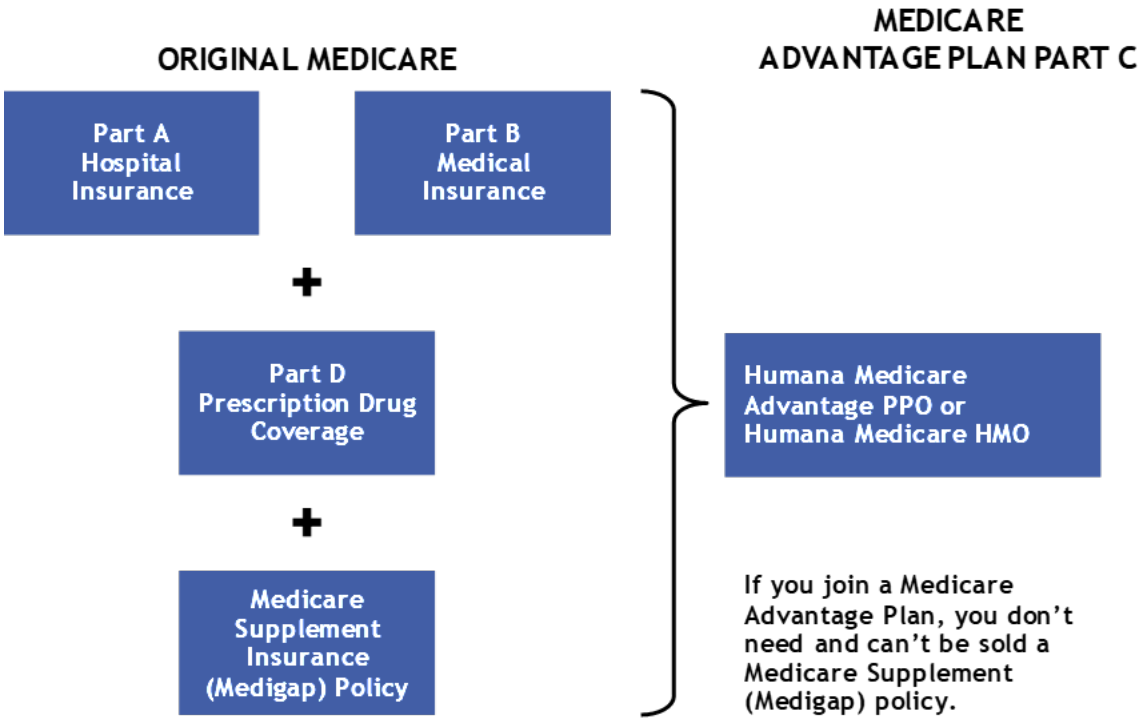
* **NOTE**: Because Sara and Mark paid their deductibles, the family deductible reached $780, so Julie would not have to pay anything to satisfy the family deductible.

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 (.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 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 15 – 17 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.

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!

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 18.

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 than 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 if you are interested in enrolling in the HMO. Visit 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.

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	• 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	• 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**.

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.

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 contributions, extra services, and prescription drugs.		
OUTPATIENT SERVICES		
Primary Care Physician Office Visit	Covered 100% All care completed within a PCP's office is covered 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	Covered 100%	Covered 100%
Preventive Injections and Immunizations	Covered 100%	Covered 100%
Routine Annual Eye Exam	Covered 100%	Covered 100%
Routine Annual Hearing Exam	Covered 100%	Covered 100%

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

	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)
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	Covered 100%	Covered 100%
Doctor and Specialist Services	Covered 100%	Covered 100%
EMERGENCY SERVICES		
Urgently Needed Care	Covered 100% after $50 copay	Covered 100% after $50 copay
Emergency Room (worldwide; waived if admitted within 48 hours)	Covered 100% after $65 copay	Covered 100% after $65 copay
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	

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 up-to-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 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 (one 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.

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 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 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.

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 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 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 2019 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 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 2019 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 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 28.

2020 Monthly Contributions

The following tables will help determine your monthly contribution. 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 Illinois counties: Cook, DuPage, Kane, Kendall, Lake, McHenry and Will.

Table I	NON-MEDICARE ONLY			
Retiree's Years of Premium Service	RETIREE ONLY		FAMILY	
	BCBS HMO	BCBS PPO	BCBS HMO	BCBS PPO
45 or more years	$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 contribution.

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 contributions shown on these pages. The Medicare Part B premium is typically deducted from your monthly Social Security benefit check.

THE DENTAL OPTION

Dental Option Highlights

MetLife is your dental benefit provider. To determine if your current dentist participates in their network, please call 800.942.0854 or visit **metlife.com/mybenefits**.

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 25 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 26 for a comparison.)

Your Monthly Contribution for Dental Coverage

Your monthly contribution for dental coverage from January 1, 2020 through December 31, 2020 is as follows:

Coverage	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 People	$117.77	$49.66	$103.07

Network Providers

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

Dental Plan Design Summary—Under Age 65 Plan

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

Dental Plan Design Summary—Over Age 65 Plans

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

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

COINSURANCE LEVEL EQUIVALENTS	HIGH PLAN BENEFIT LEVELS	LOW PLAN BENEFIT LEVELS
TYPE C EXPENSES: Paid at 50%, after deductible in High Plan only		
Endodontics (per tooth)	Once in 24 months	Not covered
Anesthesia	50%, after deductible	Not covered
Periodontics Scaling and root planing (per quadrant)	Once every 24 months	Not covered
Periodontics: Surgery (per quadrant)	Once in 36 months	Not covered
Simple and Surgical Extractions	50% after deductible	Not covered
All Other Oral Surgery	50% after deductible	Not covered
Crowns, Inlays, Onlays (replacement)	Once in 10 calendar years	Not covered
Prosthodontics	Once in 10 calendar years	Not covered
Implants	Once in 10 calendar years	Not covered
Bridges (replacement)	Once in 10 calendar years	Not covered
Additional Frequency Limitations		
Consultations	Once in 12 months	
Scaling and Root Planing	One per quadrant in any 24-month period	
Repairs	Once in 12 months	
Recementations	Once in 12 months	
Dentures	One in 10 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 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 19, 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 24 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, 2019. *Do not* send money with the form.

Completing the Enrollment Form

To keep the coverage and dependents as listed on your enclosed 2019 Statement of Benefits, there is nothing you need to do; *do not* return an enrollment form.

To make changes to your current coverage or to change your enrolled dependents, you must return the enclosed, completed enrollment form, postmarked by November 15, 2019. 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.**

AFTER YOU ENROLL

Confirmation Statement

In December, you will receive a statement confirming your medical and dental plan enrollment for coverage starting January 1, 2020. 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:

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, 2019.

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

» If your enrollment form was postmarked by November 15, 2019, 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, 2019, the confirmation statement will show the coverage on your enclosed 2019 Statement of Benefits with your 2020 monthly contribution.

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

» If your enrollment form was postmarked by November 15, 2019, 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, 2019, the confirmation statement will indicate that you are not covered under either the medical or the dental plan as of January 1, 2020. **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 2020 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 2020 will be sent in December 2019. If you are not paying with your pension check, your first payment will be due by January 1, 2020. If you are paying with your pension check, your first payment will be deducted from your January 2020 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 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

October 2019