CTA RETIREE HEALTH CARE PLAN 2012 ENROLLMENT GUIDE

FOR NON-MEDICARE ELIGIBLE RETIREES, DISABLED PENSIONERS, SURVIVING SPOUSES AND DEPENDENTS

Medical, Prescription Drug and Dental Coverage

from

January 1, 2012 through December 31, 2012

CONTACT INFORMATION

Retiree Health Care Plan Administration	Phone Number and Web Address
Group Administrators, Ltd.	1-866-997-3821 www.groupadministrators.com

PPO Plan	Phone Number and Web Address
BlueCross BlueShield of Illinois (BCBSIL) PPO	1-800-292-6398 www.bcbsil.com
Blue Care Connection (pre-certification)	1-800-247-9204 www.bcbsil.com
ComPsych (behavioral health)	1-866-645-1758 www.compsych.com
Claims submission:	ComPsych Corporation, PO Box 8379, Chicago, IL 60680-8379
CVS Caremark (prescription drugs)	1-888-797-8897 www.caremark.com

HMO Illinois Plan	Phone Number and Web Address
HMO Illinois	1-800-892-2803 www.bcbsil.com
Prime Therapeutics (prescription drugs)	1-800-423-1973 www.primetherapeutics.com

Dental Plan	Phone Number and Web Address
MetLife	1-800-942-0854 www.metlife.com/mybenefits

General Retirement	Phone Number and Web Address
CTA Retirement Office	1-866-441-9694 or 1-312-441-9694 www.ctaretirement.org

YOU MUST ENROLL FOR BENEFITS BY NOVEMBER 15, 2011

THE COVERAGE YOU CHOOSE NOW WILL REMAIN IN EFFECT FOR 12 MONTHS
FROM JANUARY 1, 2012 THROUGH DECEMBER 31, 2012
SO MAKE YOUR SELECTIONS CAREFULLY

» Please read the information in this booklet thoroughly

» If you want to keep your current coverage, do nothing; however, see the **Changes for 2012** section on page 1

» If you want to make changes, complete the enclosed enrollment form and return it to Group Administrators in the envelope provided

OPEN ENROLLMENT MEETINGS

The CTA Retirement Office is hosting two open enrollment meetings on **November 8, 2011.** The location below has ample parking, access to public transportation, and is handicapped accessible.

Tuesday, November 8, 2011

Operating Engineers 399
Union Hall & Training Facility
2260 S. Grove Street
Chicago, Illinois

You will hear a brief presentation on the changes to the health care plans for 2012 and will have the opportunity to submit questions. You will then have a chance to visit with representatives from the CTA Retirement Office and various service providers to gather more information and follow up with specific questions.

SEE THE ENCLOSED CREAM SHEET FOR A MAP AND DIRECTIONS TO THE MEETING LOCATION

MEETING SCHEDULES: ATTEND ONE MEETING	
Morning Meeting	Afternoon Meeting
Doors Open 8:45 a.m.	**Doors Open** 12:45 p.m.
Presentation and Questions & Answers 9:00 – 10:00 a.m.	**Presentation and Questions & Answers** 1:00 – 2:00 p.m.
Visiting with Service Providers 10:00 – 11:30 a.m.	**Visiting with Service Providers** 2:00 – 3:30 p.m.

PARTICIPATING SERVICE PROVIDERS	
BCBSIL PPO	CVS Caremark/SilverScript
HMO Illinois/Prime Therapeutics	Aetna
ComPsych	MetLife
Group Administrators, Ltd.	Allsup, Inc. (SSDI and Medicare Advocates)
Social Security Administration	

WHAT'S INSIDE

This guide highlights some features of the medical, prescription drug, and dental plans. If a conflict arises between this material 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.

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, 2012. These elections will remain in effect until December 31, 2012, unless you have a qualifying event as described on page 4. This guide describes the benefits available for those who are not eligible for Medicare.

Changes for 2012

For the most part, the benefits have not changed from January 1, 2011; however, there have been a few changes, which we'd like to point out to you.

» The PPO medical annual deductibles and out-of-pocket maximums as well as all medical and prescription drug copayments will increase on January 1, 2012 based on the Medical Care Consumer Price Index for the three-state area of Illinois, Indiana, and Wisconsin.

» The Classic Blue HMO from Blue Cross Blue Shield of Illinois is being eliminated. HMO Illinois and Classic Blue HMO have the same plan of benefits, but HMO Illinois does not include Northwestern Memorial Hospital and physicians. If you currently have Classic Blue HMO and do not make any elections during the open enrollment, you will be moved to HMO Illinois for the 2012 calendar year.

» There is a new provider for dental benefits. The benefit is the same as before, however the provider has changed to MetLife. See page 16 for more information on the Dental benefit.

» Monthly premiums have changed; please see the appropriate tables on pages 14-15.

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.

WHAT YOU NEED TO DO

1. Read this guide so that you understand your choices.
2. Review the enclosed 2011 Statement of Benefits. It shows your current elections and lists your current dependents.
3. If you want to keep your current elected coverage and your listed dependents as shown, you don't need to do anything—your elected coverage will continue. Do not send in the enrollment form. Remember, if you have Classic Blue HMO coverage, you will be transferred to HMO Illinois, if you don't enroll.
4. If you want to change your benefits, your coverage level, or your listed dependents, you must complete the enclosed Health Care Enrollment Form and return it in the enclosed, postage-paid envelope **BY NOVEMBER 15.**

THE OPEN ENROLLMENT PROCESS

Key things to remember:

» Your enrollment elections will be effective for 12 months, from January 1, 2012 through December 31, 2012.

» You must complete your enrollment form and it must be postmarked by Tuesday, November 15, 2011, if you want to make changes.

» If you do not enroll or miss the enrollment deadline, your current coverage as shown on the enclosed 2011 Statement of Benefits will continue until December 31, 2012.

» 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, 2011.

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 3 and 4 for details.

» How the Plan's two medical options work (pages 5-7) and the difference between the PPO and the HMO option (page 8).

» The premiums you will have to pay for medical coverage, based on the medical option and coverage level you elect. See page 13 to determine your monthly premium.

» The Plan's Dental option. See page 16 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 17 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;
- 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.

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.**

» Any dependent through age 29, who is a military veteran and:
- Is an Illinois resident;
- Is unmarried;
- Has served in the U.S. Armed Forces (including the National Guard);
- Has received a release or discharge other than a dishonorable discharge;
- 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:
- Is incapable of self-sustaining employment;
- Is dependent upon the retiree or other care provider for lifetime care and supervision because of the disability; and
- Was covered under the Plan prior to reaching the limiting age.

* 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.

Changing Your Health Benefits

Open Enrollment

You can make changes to your benefit elections during the open enrollment period - November 1, 2011 through November 15, 2011. The coverage you choose will be effective for the calendar year January 1, 2012 through December 31, 2012.

Qualifying Event

Once you enroll, your coverage will be effective for the calendar year January 1, 2012 through December 31, 2012. 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 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.

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.

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.

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, 2013.

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 indicating they were covered 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.

THE MEDICAL BENEFIT OPTIONS

The Plan offers two medical options through BlueCross BlueShield:

1. The BlueCross BlueShield of Illinois PPO
2. HMO Illinois

You and your eligible dependents must be enrolled in the same medical option. Each plan covers similar services, but has different deductibles, copayments, and network providers and premiums.

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 BlueCross BlueShield 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 $322 per person or $643 per family. Each covered person has to meet a $322 deductible; however, if the combined expenses of two or more people in a family reach $643, no further deductibles will be required of any family member for the rest of the calendar year.

Beginning January 1, 2012, you will have to satisfy your deductibles for the 2012 calendar year and the counter for out-of-pocket maximums will start again at $0.

Once you have met the deductible, 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 that 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 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 9-11.

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 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 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 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.

Examples on page 12 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 are received from network providers.

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 11 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

	BLUE CROSS BLUE SHIELD		
	PPO		HMOI
	IN NETWORK	OUT OF NETWORK	
Individual Annual Deductible	$322 individual/$643 family per calendar year		Not applicable
Lifetime Maximum	$2,000,000 per person		Unlimited
Annual Out-of-Pocket Maximum (includes psychiatric/substance abuse)	$3,217 individual/ $6,433 family	$4,289 individual/ $8,577 family	$1,500 individual/ $3,000 family
OUTPATIENT SERVICES			
Physician Office Visits (accident or illness)	90% after deductible	60% of eligible charges, after deductible	Provided in full - $10 copayment per visit
Diagnostic Services (lab tests and x-rays)	90% after deductible	60% of eligible charges, after deductible	Provided in full
Outpatient Surgery	90% after deductible	60% of eligible charges, after deductible	Provided in full
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		Provided in full - $10 copayment per visit
Injections and Immunizations	Covered under routine physical examination benefit		Provided in full
Pediatric Care	90% after deductible	60% of eligible charges, after deductible	Provided in full - $10 copayment per visit
Eye Care (Davis Vision Only 877-393-8844)	Discounts on eye exams and corrective eyewear	Not available	Eye exam paid in full after $10 copayment, $75 allowance toward pair of glasses or contact lenses every 2 years
HOSPITAL INPATIENT SERVICES			
	You must obtain BCC approval by calling 1-800-247-9204		
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

Comparison Chart (Con't)

	BLUE CROSS BLUE SHIELD		
	PPO		HMOI
	IN NETWORK	OUT OF NETWORK	
EMERGENCY SERVICES			
	You must obtain BCC 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		Primary Care Physician must be contacted except in life-threatening emergencies
Emergency Room (worldwide; waived if admitted)	$107 copayment, waived in admitted		Provided in full after $100 copayment. Waived if admitted.
Ambulance	90% of eligible charges, after deductible		Provided in full in an emergency or as ordered by HMO Illinois
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 benefit period*	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	90% 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

Comparison Chart (Con't)

	BLUE CROSS BLUE SHIELD		
	PPO		HMOI
	IN NETWORK	OUT OF NETWORK	
BEHAVIORAL HEALTH SERVICES	ComPsych Network	Non-ComPsych Network	
Prior to any Mental Health or Chemical Dependency Treatment, or within one business day of any emergency admission, you must call ComPsych Corporation at 1-888-808-1884.			
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 ComPsych 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 CVS Caremark Mail Service Pharmacy. THE PRESCRIPTION DRUG BENEFITS MANAGER FOR BCBSIL PPO IS CVS CAREMARK, FOR HMOI IT IS PRIME THERAPEUTICS.			
Generic			**Generic**
Retail (30 day supply)	$11 copayment		$5 copayment
Mail Order (90 day supply)	$21 copayment		$10 copayment
Brand Name Drugs on the Formulary List (if no generic)			**Preferred**
Retail (30 day supply)	$21 copayment		$10 copayment
Mail Order (90 day supply)	$43 copayment		$20 copayment
Brand Name Drugs Not on the Formulary or Brand Name Drugs with a Generic Equivalent Available			**Non-Preferred**
Retail (30 day supply)	$54 copayment		$25 copayment
Mail Order (90 day supply)	$107 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:	- $322.00
Remaining Expense:	$1,478.00
Plan Pays 90%	$1,330.20
Sam Pays 10%	$147.80

In total, the Plan would pay $1,330.20 and Sam would pay $469.80 (deductible plus 10%). The $469.80 Sam paid would count toward his annual out-of-pocket maximum of $3,217.

If Sam did not use a network provider, his costs would have been $322 (deductible) plus 40% of a higher expense because there was no PPO discount (at least $591.20).

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	- $322.00	- $321.00	$0.00*	- **$643.00**
3. Remaining Expenses	$2,178.00	$429.00	$1,500.00	**$4,107.00**
4. Plan Pays 90%	$1,960.20	$386.10	$1,350.00	**$3,696.30**
5. Sara's Family Pays 10%	$217.80	$42.90	$150.00	**$410.70**
Total Plan Pays (4)	$1,960.20	$386.10	$1,350.00	**$3,696.30**
Total Sara's Family Pays (2 +5)	$539.80	$363.90	$150.00	**$1,053.70**

* **NOTE**: Because Sara and Mark paid their deductibles, the family reached the $643 family deductible and Julie did not have to satisfy the deductible.

In total, the Plan would pay $3,696.30 and Sara's family would pay $1,053.70 (family deductible plus 10%). The $1,053.70 Sara's family paid would count toward their annual out-of-pocket maximum of $6,433.00.

If Sara's family had received services from non-network providers, their costs would have been $643.00 (family deductible) plus 40% of a higher expense because there was no PPO discount (at least $1,642.80).

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 2011 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.**

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 14-15:
   - **Table I:** Non-Medicare only – Retiree only or Family.
   - **Table II:** Retiree on Medicare, at least one dependent not Medicare eligible.
   - **Table III:** At least one dependent Medicare eligible; retiree not Medicare eligible.
   - **Table IV:** Surviving spouse and/or any dependent child not Medicare eligible.
2. **Identify your years of premium service in the far-left column.** Your Years of Premium Service Category is shown on your enclosed 2011 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. If you are enrolling in Family Combined coverage because one or more of your family members are Medicare eligible, you will also need to identify the Aetna option your Medicare eligible family members will elect (Aetna Plus or Aetna Basic).
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 17.

2012 Monthly Premiums

The following tables will help determine your monthly premium cost. See page 13 to determine which table to use.

TABLE I	NON-MEDICARE ONLY			
	RETIREE ONLY		FAMILY NON-MEDICARE	
Retiree's Years of Premium Service	HMO	PPO	HMO	PPO
35 or more years	$36	$42	$384	$447
30 to less than 35 years	$71	$83	$419	$488
25 to less than 30 years	$201	$234	$665	$775
20 to less than 25 years	$294	$342	$797	$928
15 to less than 20 years	$503	$586	$1,044	$1,217
10 to less than 15 years	$580	$676	$1,160	$1,352
Less than 10 years	$696	$811	$1,392	$1,622

TABLE II	FAMILY COMBINED - MEDICARE RETIREE, PLUS ANY DEPENDENT(S) NOT ON MEDICARE			
Medicare Retiree and Dependents =	Aetna Plus		Aetna Basic	
Non-Medicare Dependent(s) =	HMO	PPO	HMO	PPO
Retiree's Years of Premium Service				
35 or more years	$360	$417	$356	$413
30 to less than 35 years	$371	$428	$364	$421
25 to less than 30 years	$534	$611	$513	$590
20 to less than 25 years	$596	$679	$569	$652
15 to less than 20 years	$692	$782	$648	$738
10 to less than 15 years	$755	$851	$703	$799
Less than 10 years	$906	$1,021	$844	$959

TABLE III	FAMILY COMBINED - RETIREE NOT ON MEDICARE, PLUS SPOUSE AND/OR DEPENDENT(S) ON MEDICARE			
Non-Medicare Retiree and Dependents=	HMO		PPO	
Medicare Dependent(s) =	Aetna Plus	Aetna Basic	Aetna Plus	Aetna Basic
Retiree's Years of Premium Service				
35 or more years	$152	$118	$158	$124
30 to less than 35 years	$187	$153	$199	$165
25 to less than 30 years	$352	$308	$385	$341
20 to less than 25 years	$445	$401	$493	$449
15 to less than 20 years	$666	$618	$749	$701
10 to less than 15 years	$755	$703	$851	$799
Less than 10 years	$906	$844	$1,021	$959

TABLE IV	SURVIVING SPOUSE AND/OR ANY DEPENDENT CHILD NOT MEDICARE ELIGIBLE	
Retiree's Years of Premium Service	HMO	PPO
35 or more years	$348	$405
30 to less than 35 years	$348	$405
25 to less than 30 years	$464	$541
20 to less than 25 years	$503	$586
15 to less than 20 years	$541	$631
10 to less than 15 years	$580	$676
Less than 10 years	$696	$811

THE DENTAL OPTION

Dental Option Highlights

Effective January 1, 2012, MetLife will be your dental benefit provider. To determine if your current dentist participates in their network, please call 1-800-942-0854 or go to their website at www.metlife.com/mybenefits.

Your coverage will terminate the last day of the month prior to your 65th birthday. **However, 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 the enclosed MetLife brochure or contact MetLife for additional information.

Your Monthly Contribution for Dental Coverage

Your monthly premium cost for dental coverage from January 1, 2012 through December 31, 2012 is as follows:

- One Person: $34.80
- Two People: $69.50
- Three or More: $102.00

BENEFITS/PROCEDURES	DENTAL PPO PLAN[1]
Deductible per Person	$25
Deductible per Family	$50
Annual Maximum Benefit (per person)	$2,000 per calendar year
Oral Exam (two per calendar year)	100%
Routine Cleaning (two per calendar year)	100%
Topical Fluoride Treatment (two per calendar year)	100% (for a child under age 14)
Sealant	100% (for a child under age 14)
X-rays (limitations apply)	90%
Silver Filling	90%
Composite Fillings	90%
Root Canal (molar)	90%
Scaling & Root Planning (per quad)	90%
Osseous Surgery (per quad)	90%
Single Tooth Extraction	90%
Surgical Tooth Extraction	90%
Removal Complete Bony Impaction	90%
Porcelain Crown Fused to Metal	50%
Post and Core (in addition to Crown)	50%
Complete Upper or Lower Denture	50%
Partial Upper or Lower Denture	50%
Orthodontia (braces) for children or adults	N/A

[1]Percentage of reasonable and customary charges after deductible has been met

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 13, 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 16 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 2011 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, 2011. 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, 2011. You do not need to send any money with the form.

1. **Complete the *Participant Information* section completely.** 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 completely.** Be sure to include each dependent's relationship to you, his or her date of birth, and his or her Social Security Number.
3. **Indicate whether you are declining or electing medical coverage.** If you are electing medical coverage, be sure to indicate the plan you want and the type of coverage you want.
4. **Indicate whether you are declining or electing dental coverage.** If you are electing dental coverage, be sure to indicate the type of coverage you want.
5. **Review the form when you finish, to be sure it is complete and accurate.**
6. **Sign the *Certification* section.**

AFTER YOU ENROLL

Confirmation Statement

In December, you will receive a confirmation statement that indicates your medical and dental plan enrollments effective January 1, 2012. 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 2011 Statement of Benefits with your 2012 monthly premium. If you currently have Classic Blue HMO, the confirmation statement will show that you have been moved to HMO Illinois.

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, 2011.

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, 2012. 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 2012 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 2012 will be sent in December 2011 with your confirmation statement. If you are not paying with your pension check, your first payment will be due by January 1, 2012. If you are paying with your pension check, your first payment will be deducted from you January 2012 pension check.

Notice About The Early Retiree Reinsurance Program

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, the CTA RHCT may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the CTA RHCT chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and the CTA RHCT chooses to use the reimbursements for this purpose. The CTA RHCT may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

c/o Group Administrators, Ltd.
915 National Parkway, Suite F
Schaumburg, Illinois 60173
1-866-997-3821
www.ctaretirement.org

October 2011

Dear Non-Medicare Eligible CTA Retiree or Surviving Spouse:

Enclosed is your open enrollment packet for your CTA RHCT coverage for the calendar year January 1, 2012 through December 31, 2012. The packet contains:

- Your Personalized 2011 Statement of Benefits;
- The open enrollment guide for non-Medicare Eligible participants, which contains the directions to the **meetings on November 8** (cream sheet), your enrollment form and return envelope; and
- The MetLife Dental Brochure. MetLife is the new dental provider. Dental benefits have not changed. See page 16 of the brochure for information on the dental plan.

Please read the information in the packet carefully as there have been changes to the options and to the premiums. The **open enrollment period will be November 1 through November 15**.

If you plan to continue the coverage you have currently, you will not need to re-enroll; however, you should read the enrollment guide so that you understand the changes to the options and premiums that will go into effect January 1, 2012.

One change is that **the Classic Blue HMO will not be available beginning January 1, 2012**. HMO Illinois and Classic Blue HMO have the same plan of benefits, but HMO Illinois does not include Northwestern Memorial Hospital and physicians in its network. If you currently have Classic Blue HMO and do nothing, your coverage will automatically transfer to HMO Illinois; if you do not want HMO Illinois coverage, you must complete and return the enrollment form with your elected coverage.

This packet is for non-Medicare eligible retirees, surviving spouses, and dependents only. If you or any of your dependents will be eligible for Medicare on January 1, 2012, please call Group Administrators at 1-866-997-3821 **immediately** to request the appropriate packet.

Sincerely,

Board of Trustees –

CTA Retiree Healthcare Trust

Directions

International Union of Operating Engineers
Local 399

Union Hall and Training Facility
2260 South Grove Street
Chicago, IL 60616

November 8, 2011

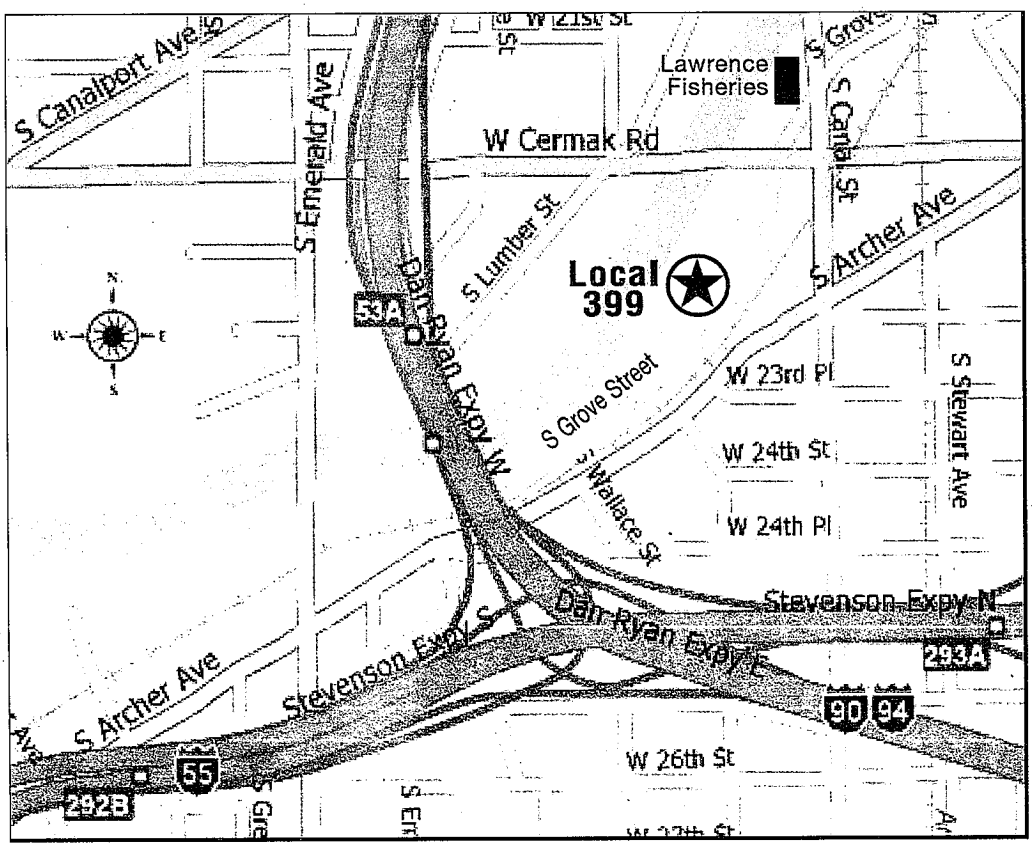
	Morning Meeting	*Afternoon Meeting*
Doors Open	8:45 a.m.	12:45 p.m.
Presentation and Questions & Answers	9:00 – 10:00 a.m.	1:00 – 2:00 p.m.
Visiting with Service Providers	10:00 – 11:30 a.m.	2:00 – 3:30 p.m.

Driving Directions

From the Northwest:
Take 90/94 East to Roosevelt Road Exit. Turn left on East Roosevelt Road. Turn right on South Canal Street. At Lawrence Fisheries Restaurant, merge right onto South Grove Street and follow to Union Hall.

From the South:
Take 1-57 to 1-94 West. Exit 22nd/Cermak Street (Chinatown) exit. Take Cermak Road West. Turn left on South Grove Street (just past Canal Street) and follow to Union Hall.

From the Far West:
Take 1-88 East (toll) and merge onto 1-290 East. Exit 90/94 East to Roosevelt Road Exit. Turn left on East Roosevelt Road. Turn right on South Canal Street. At Lawrence Fisheries Restaurant, merge right onto South Grove Street and follow to Union Hall



CHICAGO TRANSIT AUTHORITY—RETIREE HEALTH CARE TRUST
c/o Group Administrators, Ltd. • 915 National Parkway, Suite F, Schaumburg, IL 60173

HEALTH CARE ENROLLMENT FORM - NON-MEDICARE ELIGIBLE

FOR RETIREES, DISABLED PENSIONERS, SURVIVING SPOUSES AND DEPENDENTS

2012 OPEN ENROLLMENT

for coverage from January 1, 2012 through December 31, 2012

☐ Check this box if you are making changes to your 2012 elections or dependents.

IF YOU ARE NOT MAKING CHANGES, DO NOT SEND IN THIS FORM.

INSTRUCTIONS

- Please complete all sections of this form. You must type or print all information.
- Sign the form and return it with all required documentation to Group Administrators using the envelope provided.
- **Do not send any money with this form.** If your monthly pension is not sufficient to cover your premium cost, you will receive a bill for the first month's premium along with your enrollment confirmation in December.
- If you need assistance, contact Group Administrators at 866.997.3821 or help@ctaretirement.org.
- **Enrollment forms must be mailed no later than November 15, 2011.**
- After your enrollment form is received, you will be notified if further information is required.

RETIREE OR SURVIVING SPOUSE INFORMATION

Name: _____ _____ _____
First Middle Last

Home Address: _____ _____
Street/Unit Number City/State/Zip Code

Home Phone: _____ Cell phone: _____ Email: _____
(optional) *(optional)*

Status: ☐ Retiree ☐ Surviving Spouse Social Security #: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ Date of Retirement: ____ ____ ____
Month Day Year Month Day Year

GO TO NEXT PAGE

DEPENDENT INFORMATION

Please list only those dependents who are eligible for coverage and that you are currently enrolling. If you have more than five dependents, please list the additional dependents on a separate sheet of paper. If you are adding your eligible spouse or dependents for the first time, you must provide the necessary documentation. **Please note that the term "spouse" includes legally married spouse, same-sex domestic partner, or civil union partner.**

DEPENDENT 1

Name: _____ _____ _____
First Middle Last
Relationship to Retiree: _____ Gender: ☐Male ☐Female
Date of Birth: ____ ____ ____ Social Security #: _____
Month Day Year

DEPENDENT 2

Name: _____ _____ _____
First Middle Last
Relationship to Retiree: _____ Gender: ☐Male ☐Female
Date of Birth: ____ ____ ____ Social Security #: _____
Month Day Year

DEPENDENT 3

Name: _____ _____ _____
First Middle Last
Relationship to Retiree: _____ Gender: ☐Male ☐Female
Date of Birth: ____ ____ ____ Social Security #: _____
Month Day Year

DEPENDENT 4

Name: _____ _____ _____
First Middle Last
Relationship to Retiree: _____ Gender: ☐Male ☐Female
Date of Birth: ____ ____ ____ Social Security #: _____
Month Day Year

DEPENDENT 5

Name: _____ _____ _____
First Middle Last
Relationship to Retiree: _____ Gender: ☐Male ☐Female
Date of Birth: ____ ____ ____ Social Security #: _____
Month Day Year

GO TO NEXT PAGE

MEDICAL COVERAGE

Declining Medical Coverage

If you are declining medical coverage for yourself, your spouse, and/or your dependent children, please indicate which coverage you are declining. ***Check all that apply.***

☐ **I am declining medical coverage for MYSELF at this time**. I understand that if I do this, I only have ***one*** opportunity to enroll – *either* when I lose coverage under another plan, during an annual open enrollment period, *or* when I become eligible for Medicare. I also understand that I must provide documentation indicating that I was covered under another plan immediately prior to the date I want to join this plan. Finally, I understand that if I am a retiree/surviving spouse and I opt out of coverage at any time, I cannot elect coverage for my dependents.

☐ **I am declining medical coverage for MY SPOUSE at this time (retirees only)**. I understand that if I do this, my spouse only has ***one*** opportunity to enroll – *either* when he/she loses coverage under another plan, during an annual open enrollment period, in the event of my death, *or* when he/she becomes eligible for Medicare. I also understand that I must provide documentation indicating that he/she was covered under another plan immediately prior to the date he/she wants to join this plan.

☐ **I am declining medical coverage for MY ELIGIBLE DEPENDENT CHILDREN at this time**. I understand that if I do this, they only have ***one*** opportunity to enroll – *either* when they lose coverage under another plan, during an annual open enrollment period, in the event of my death if my eligible spouse converts to surviving spouse coverage (retirees only), *or* when they become eligible for Medicare. I also understand that I must provide documentation indicating that they were covered under another plan immediately prior to the date they want to join this plan.

Electing Medical Coverage

I am electing coverage under the following plan for myself or my dependents:

☐ BlueCross BlueShield of Illinois PPO ☐ HMO Illinois

I am electing the following coverage for myself and my dependent(s) under the plan:

☐ Retiree Only (includes disabled pensioners)	☐ Surviving Spouse (includes surviving spouse and/or dependent children)	☐ Family (includes retiree, spouse, and/or dependent children)

GO TO NEXT PAGE

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DENTAL COVERAGE

Declining Dental Coverage

If you are declining dental coverage for yourself, your spouse, and/or your dependent children, please indicate which coverage you are declining. ***Check all that apply.***

☐ **I am declining dental coverage for MYSELF at this time**. I understand that if I do this, I will be able to enroll in this plan when I lose coverage under another plan or during the next open enrollment period.

☐ **I am declining dental coverage for MY ELIGIBLE DEPENDENTS at this time**. I understand that if I do this, I will be able to enroll them in this plan when they lose coverage under another plan or during the next open enrollment period.

Electing Dental Coverage

I am electing the following dental coverage for myself and/or my dependent(s) who are under age 65 (or my spouse over age 65, if I, the retiree, am under age 65):

☐ One Person

☐ Two People

☐ Three or More People

CERTIFICATION

I authorize Group Administrators to enroll me in the medical and dental plans I have indicated on this form. I understand that I am responsible for paying the total premium each month and I authorize the CTA Retirement Plan to deduct the premiums from my monthly pension check if it is sufficient to cover the premium. If my monthly pension check is less than the total monthly premium, I understand I will receive a bill and I agree to pay the full premium directly to the CTA Retiree Health Care Trust.

I certify that, to the best of my knowledge, the information provided on this form is true and accurate and that any dependents listed are eligible for coverage under the criteria described in the Enrollment Guide. I understand that I must notify Group Administrators within 30 days of the date any dependent ceases to be eligible for coverage. I understand that enrolling a dependent who is not eligible, or failing to provide notice of ineligibility, may result in the retroactive termination of coverage for me and my dependents, as well as liability for any benefits paid by the Plan on behalf of any ineligible dependent.

Signature: _____ Date: _____

Make a Copy for Your Records and Return as per Instructions