2024 Open Enrollment

October 15 - November 15, 2023 for
Aetna Health Plan Enrollment/Changes

OR

November 1 - December 31, 2023 for
NYSHIP Health Plan Enrollment/Changes

Health Benefits Summary

New York City Transit

SSSA/TSO Operating & Queens Division/
TSO MS II/MTA Bus TSO Local 106
Active Employees

MTA Business Service Center
www.mymta.info

Disclaimer

This Summary contains information concerning some of the benefits you are entitled to as an MTA New York City Transit employee. This Summary is for informational purposes only and may be modified at any time. If a conflict exists between this Summary and an official written document setting forth the benefit, policy, procedure, or rule, the official written document controls.

It is important to note that all benefits summarized herein are the benefits that are currently in effect at New York City Transit. These benefits are all subject to change, including termination, at any time in the sole discretion of New York City Transit, except to the extent that they have been established by collective bargaining agreement or are required by law. Some benefit programs, such as public retirement plans, are administered and interpreted outside of New York City Transit. If the information contained in this Summary conflicts with the provisions of any benefit program, the program's policies control.

CONTENTS

1 INTRODUCTION

Open Enrollment Period: October 15 - November 15 for Aetna Health Plan **OR** November 1 - December 31 for NYSHIP Health Plan

Plan changes will be effective January 1, 2024

Reminder…to remain in your current medical plan, no action is required.

The Business Service Center (BSC) processes all medical benefit enrollments and changes. For assistance, contact us at 646-376-0123 or bscservice@mtabsc.org.

During the Open Enrollment period, you may…

- Change plans
- Add, change, and/or remove dependents

Available online on My MTA Portal (www.mymta.info/openenrollment)…

- Open Enrollment Recorded Informational Webinars
- Summary of Health Benefits
- Medical enrollment/change forms
- Flexible Spending Account enrollment information
- Opt-Out Program brochure and form

Dates to remember…

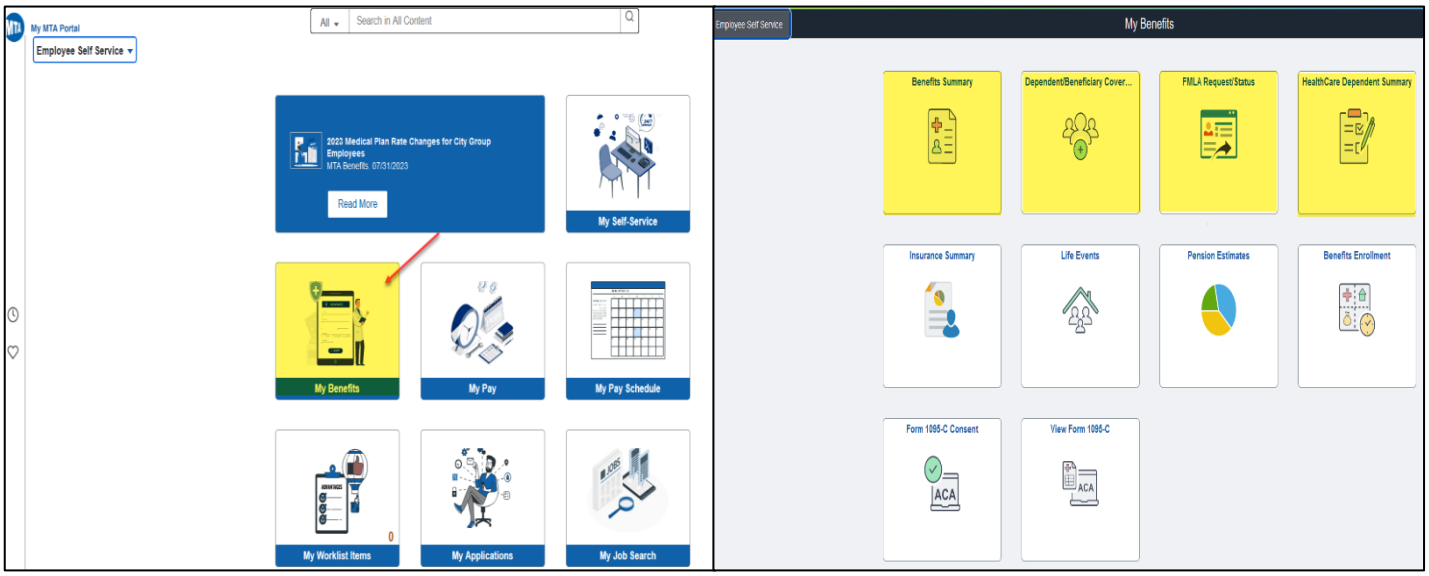
You can access information on the MTA Opt-Out and Tax-Favored programs via the BSC website and the provider websites. Go to www.mymta.info/openenrollment.

- **Medical Opt-Out Program: October 15 - November 15 for Aetna Health Plan OR November 1 - December 31 for NYSHIP Health Plan**
- Flexible Spending Account (FSA): November 1 - December 15

2 HOW TO MAKE CHANGES

- **To make medical and/or dental plan changes via form and/or to <u>add a *new* dependent</u>**, submit the below enrollment form(s) as applicable:
  - **HR-BEN-810K** 2024 Open Enrollment/Change Form for Active NYCT SSSA/TSO Operating & Queens Division/TSO MSII/MTA Bus TSO Local 106 Employees
  - **HR-BEN-060K** 2024 NYSHIP Open Enrollment/Change Form
  - **HR-BEN-810N** 2024 Dental Open Enrollment/Change Form for Active NYCT SSSA/TSO Operating & Queens Division/TSO MSII/TSO SSII/MTA Bus TSO Local 106/Special Inspector (UFLEO) Employees with NYSHIP Health Plan

- **Use online services to review all your benefits information:**



3 HEALTH BENEFIT CHOICES for Aetna Health Plan

Electing or Changing Medical/Dental/Vision Coverage

Medical/Hospital	Prescription Drugs	Dental	Vision
Aetna CPOS II Basic Option	CVS Caremark	CIGNA Dental Care (DHMO) **OR** CIGNA DPPO	EyeMed
Aetna Select Option (National provider network allows you to see Aetna participating providers within the United States)	CVS Caremark	CIGNA Dental Care (DHMO) **OR** CIGNA DPPO	EyeMed

Medical Plan Options for Aetna Health Plan

January 1, 2024 Aetna Options for Active SSSA/TSO Operating & Queens Division/TSO Maintenance Supervisor II/MTA Bus TSO Local 106 Members with Aetna Health Plan

This is a summary of major in-network benefits available under each plan

Benefit		Aetna CPOS II Basic In-network (Out-of-network coverage available)	Aetna Select Option In-network (National network ONLY coverage)*
Deductible		DME $100 per person per calendar year	DME $100 per person per calendar year
Out-of-pocket maximum		N/A	N/A
Lifetime maximum		Unlimited	Unlimited
Office visits:	- Primary care office visit	$15 copay	100% coverage
	- Specialist office visit	$15 copay	100% coverage
	- Preventive care visit	$0 copay	100% coverage
Inpatient hospital deductible		$50 per person per confinement; $240 per person or family max per calendar year	N/A
Inpatient hospital		100% coverage after deductible	100% coverage
Outpatient hospital		100% coverage	100% coverage
Emergency room		$100 copay	$100 copay
Mental health:	- Office visit	$15 copay	100% coverage
	- Inpatient	100% coverage after deductible	100% coverage
Substance abuse:	- Office visit	$15 copay	100% coverage
	- Inpatient	100% coverage after deductible	100% coverage
Behavioral/Physical/ Occupational & Speech Therapy:		$15 copay	$0 copay

***National provider network allows you to see Aetna participating providers within the United States.**

Note to All Employees Planning to Retire in 2024

If you and/or your covered dependent become Medicare eligible as a result of reaching at least age 65 or being disabled when you retire, Medicare will be you and/or your dependent's primary medical coverage.

Please ensure that you and/or your covered dependent(s) enroll in Medicare.

Enrollment in Medicare generally takes about three months, so please contact the Social Security Administration in advance so that as a retiree, you and/or your dependent will be enrolled in Medicare Part A (hospitalization) and Medicare Part B (medical). Your medical plan choices at that time will be Aetna CPPO II Basic Option and the Aetna Medicare Advantage Options 1 or 2.

Value Added Benefits	Aetna CPOS II Basic	Aetna Select Option
Informed Health Line 24/7 Nurse Line **call 1-800-556-1555 (TTY:711)** to speak with a registered nurse	Included	Included
Condition Management nurse support for chronic conditions such as Diabetes and Asthma	Included	Included
Discount Programs gym memberships, eye care, hearing and dental products	Included	Included

Note: All calls are confidential

Prescription Drug Plan

Your prescription drug plan is administered by CVS Caremark. Your coverage is based on a three-tiered formulary according to the following schedule:

CVS Caremark Prescription Drug Plan

Benefit	Aetna CPOS II Basic	Aetna Select Option
Retail (up to 30-day supply)		
Tier 1: Generic	$0	$0
Tier 2: Formulary Brand	$20	$20
Tier 3: Non-Formulary Brand	$40	$40
Mail Order (up to 90-day supply) Mandatory		
Tier 1: Generic	$0	$0
Tier 2: Formulary Brand	$40	$40
Tier 3: Non-Formulary Brand	$80	$80

Mandatory Mail Order: if you are on a maintenance medication, you **MUST** obtain your medication(s) through the CVS Caremark Mail Service Pharmacy. Any prescription drug that has been filled two times at a participating pharmacy (original prescription plus one refill) **MUST** be sent to the CVS Caremark Mail Service Pharmacy for all additional fills. All initial prescriptions sent to the CVS Caremark Mail Service Pharmacy **MUST** be sent with a new prescription from your physician and should be written for up to a 90-day supply.

4 HEALTH BENEFIT CHOICES for NYSHIP Health Plan

To assist with your decision-making, please review the **2024 NYSHIP Choices Guide**, which lists all your plan choices. The NYSHIP Choices Guide is available on the 2024 open enrollment website at www.mymta.info/openenrollment.

The **2024 Employee Contribution Rates** will be available on the My MTA Portal in December. It will include information on the following options:

- **The Empire Plan Rates Preferred Provider Organization (PPO)**
- **The NYSHIP Approved Health Maintenance Organizations Rates (HMO)**

If you opt to make a change, it is important that you choose carefully because you will *not* be able to change your health insurance option after the December 31, 2023 open enrollment deadline, except if the option you are enrolled in no longer services the area in which you live. To make changes to your current NYHIIP Health Plan enrollment, please complete and submit:

- **HR-BEN-060K 2024 NYSHIP Open Enrollment/Change Form**

You may also change your enrollment status/options if you experience a qualifying life event, such as marriage, divorce, birth or adoption of a child, loss of dependent child status, or loss of coverage. **If you experience a qualifying life event, it is important that you update your records by submitting the appropriate forms to the MTA BSC within thirty (30) days of the qualifying event date.**

Please note that medical insurance contribution costs to cover you and/or your family are made via payroll deduction on a *pre-tax* basis, while contributions that cover a domestic partner are withheld via payroll deduction on a *post-tax* basis.

The dental plan options available to you and your eligible dependents are:

- **CIGNA Dental Care (DHMO)**
- **CIGNA DPPO**

To enroll in or make changes to your dental plan, please complete and submit:

- **HR-BEN-810N 2024 Dental Open Enrollment/Change Form**

Vision benefits are available to you and your eligible dependents through EyeMed.

Note to All Employees Planning to Retire in 2024

If you and/or your covered dependent become Medicare eligible as a result of reaching at least age 65 or being disabled when you retire, Medicare will be you and/or your dependent's primary medical coverage. This will occur on the first of the month *or* the following month coinciding with your retirement date.

Please ensure that you and/or your covered dependent(s) enroll in Medicare.

Enrollment in Medicare generally takes about three months, so please contact the Social Security Administration in advance so that as a retiree, you and/or your dependent will be enrolled in Medicare Part A (hospitalization) and Medicare Part B (medical) upon retirement.

5 DENTAL & VISION BENEFIT CHOICES for AETNA OR NYSHIP HEALTH PLANS

Dental and Vision Plan Options

Dental	Vision
CIGNA Dental Care (DHMO)	EyeMed
CIGNA DPPO	

DENTAL	Cigna DPPO Dental		Cigna Dental Care (DHMO)
Network Access	DPPO In-Network	DPPO Out-of-Network	DHMO
	In-Network Highlights	**Out-of-Network Highlights**	**In-Network Only**
Deductible	$0	$0	$0
Annual Maximum	$2,500 Indv./$5,000 Fam	$2,500 Indv./$5,000 Fam	$0
Orthodontics up to age 23, if banded up to age 26	$0	100% of schedule amount	$0 Copay
Oral Examination & Diagnosis	$0	100% of schedule amount	$0 Copay
X-Rays	$0	100% of schedule amount	$0 Copay
Fluoride Treatment	$0	100% of schedule amount	$0 Copay
Filling	$0	100% of schedule amount	$0 Copay
Root Canal	$0	100% of schedule amount	$0 Copay
Crowns and Bridges	$0	100% of schedule amount	$0 Copay

VISION		
EYEMED	**In-Network**	**Out-of-Network Maximum Reimbursement**
Once every 12 months		
Eye Exam	$0 copay	Up to $40
Retinal Imaging	Up to $39	
Frames	$0 copay; 20% off balance over $180 allowance	Up to $75
Lenses		
Single Vision	$20 copay	Up to $30
Bifocal	$20 copay	Up to $40
Trifocal	$20 copay	Up to $50
Lenticular	$20 copay	Up to $180
Progressive Standard	$70 copay	Up to $75
Contact lenses in lieu of lenses	$0 copay 15% off balance over $100	Up to $100

Dependent Coverage

Dependent Coverage				
When coverage ends	**Age 19**	**Age 21**	**Age 25**	**Age 26**
MEDICAL/HOSPITAL				
Basic and Select Option	N/A	N/A	N/A	End of Month
PRESCRIPTION				
CVS Caremark	N/A	N/A	N/A	End of Month
DENTAL				
Cigna DPPO Dental	N/A	N/A	N/A	End of Month
Cigna Dental Care (DHMO)	N/A	N/A	N/A	End of Month
VISION				
Vision Plan	N/A	N/A	N/A	End of Month

Full Time Student Status Verification is not required

6 MEDICAL OPT-OUT PROGRAM

Opt-Out Program for Medical/Hospital and Prescription Drugs…

If you have or will have alternate medical coverage as of the upcoming plan year, you can take advantage of the MTA's Medical Opt-Out Program. **Your dental and vision coverage will remain in effect even if you elect to enroll in the Opt-Out Program.**

General Overview of the Opt-Out Process:

1. **If you previously enrolled in the Opt-Out Program in 2023 and wish to continue in the Opt-Out Program for 2024:**
   - **NO ACTION REQUIRED:** Your opt-out status will remain in place for 2024

2. **If you previously enrolled in the Opt-Out Program in 2023 and now wish to *re-enroll* in Medical/Hospital and Prescription Drug Coverage for 2024, you MUST:**
   - Complete the **HR-BEN-810K** 2024 Open Enrollment/Change Form if you are interested in enrolling in the *Aetna Health Plan*, and submit to the BSC, **by November 15, 2023**

     OR

   - Complete the **HR-BEN-060K** 2024 NYSHIP Open Enrollment/Change Form if you are interested in enrolling in the *NYSHIP Health Plan*, and submit to the BSC, **by December 31, 2023**

3. **If you are currently enrolled in Medical/Hospital and Prescription Drug Coverage for 2023 and wish to *enroll* in the Medical Opt-Out Program for 2024, you MUST:**
   - Complete the ***Opt-Out Program* section** on the **HR-BEN-810K** 2024 Open Enrollment/Change Form if currently enrolled in the *Aetna Health Plan*, and submit to the BSC, **by November 15, 2023**

     OR

   - Complete the **HR-BEN-036** Agreement to Decline (Opt-Out) Medical Coverage Non-Represented & Eligible Represented Employees Form, if currently enrolled in the *NYSHIP Health Plan*, and submit to the BSC, **by December 31, 2023**

Additional Information about the Medical Opt-Out Program:

1. To opt-out of medical/hospital and prescription drug coverage, you ***must*** provide proof you have coverage under an alternate medical plan or will have coverage by January 1, 2024

2. **For Active SSSA (EXCEPT SSSA Confidential) and MTA Bus TSO Local 106 employees**, if you participate in the Medical Opt-Out Program and separate from MTA service *before* the end of the opt-out year, you will **not** be eligible to receive any part of the incentive payment
   - **For 2024, the individual opt-out incentive payment is $550**
   - **For 2024, the family opt-out incentive payment is $1,100**

3. **For the Active SSSA Confidential, TSO Operating & Queens Division, and TSO MS II employees** listed below, if you participate in the Medical Opt-Out Program and separate from MTA service *before* the end of the opt-out year, the incentive payment will be pro-rated based on the months of enrollment in the Opt-Out Program
    - **For 2024, the individual opt-out incentive payment is $1,000**
    - **For 2024, the family opt-out incentive payment is $3,000**

NYCT-SSSA CONFIDENTIAL
NYCT-TRANSIT SUPERV ORG OP SUP
NYCT-TRANSIT SUPERV ORG QUEENS
NYCT-TRANSIT SUPRV ORG COIN RETR
NYCT-TSO/MS II
NYCT-TSO/MS II CONFIDENTIAL

4. Based on union affiliation, the payment of the lump-sum incentive will be made at the *end* of the opt-out year **or** the *beginning* of the next calendar year following the opt-out year
    - For the active *SSSA (**EXCEPT** SSSA Confidential) and MTA Bus TSO Local 106 employees listed in bullet point #2* above, the lump-sum incentive will be paid out in December 2024
    - For the active *SSSA Confidential, TSO Operating & Queens Division, and TSO MS II employees listed in bullet point #3* above, the lump-sum incentive will be paid out in January 2025

5. You have the option to defer your opt-out incentive payment to your 401(k) or 457 plans
    - To do so, you **MUST** submit the **HR-DEFCOMP-075** Medical Opt-Out Deferred Compensation Lump Sum Deferral form **every year**

6. The incentive payment is subject to all applicable federal, state, and local taxes and is not considered pensionable income (it will not be included in any pension calculations)

7. As a ***represented*** employee, contributions during the opt-out period will be subject to the terms of the applicable collective bargaining agreement

8. If you *waived* health plan coverage as a new hire in 2023 and wish to enroll in the Opt-Out Program for 2024, you **MUST** submit a request to opt-out during your respective Open Enrollment period

9. The election to opt-out remains in effect until you change your election during a future Open Enrollment period **OR** experience a Qualified Family Status/Life Event Change

7 LEGAL REQUIREMENTS

Coverage for Dependent Children

A dependent child aged 19 to 26 is eligible for medical, hospital, prescription drug, dental, and vision coverage, regardless of their student or marital status.

- To enroll a dependent child, age 19 to 26, submit the **HR-BEN-810K** 2024 Open Enrollment/Change Form **OR** the **HR-BEN-060K** 2024 NYSHIP Open Enrollment/Change Form, as applicable

Submit the applicable form with all required supporting documentation, and affirm, by signing the form, that your child is eligible for coverage.

Social Security Number Requirement

The Medicare, Medicaid, and State Children's Health Insurance Extension Act of 2007 (MMSEA) requires MTA New York City Transit to report Social Security Numbers to the Federal Centers for Medicare and Medicaid Services (CMS) for all dependents who are at least age 45.

You can check to see if a covered dependent's Social Security Number is missing from your benefits record by signing on to My MTA Portal at www.mymta.info. Click on the **My Benefits** tile, then click the **Health Care Dependent Summary** tile. Click the dependent's name to view their personal information.

If a dependent's Social Security Number is not shown under SSN (only the last four digits will show), please submit to the MTA BSC, a copy of the dependent's Social Security Card with your name and BSC ID number noted on the copy, along with *either*:

- **HR-BEN-810K** 2024 Open Enrollment/Change Form for Active NYCT SSSA/TSO Operating & Queens Division/TSO MSII/MTA Bus TSO Local 106 Employees
  OR
- **HR-BEN-060K** 2024 NYSHIP Open Enrollment/Change Form

Be sure to include your name and BSC ID number on the copy of the Social Security Card(s).

8 IMPORTANT TELEPHONE NUMBERS & WEBSITES

Medical/Hospital - Aetna Health Plan		
Aetna CPOS II Basic	855-824-5349	www.aetnaNYCT.com
Aetna Select Option	855-824-5349	www.aetnaNYCT.com
Aetna 24/7 Health Line	800-556-1555 (TTY:711)	www.aetnaNYCT.com
Medical/Hospital & Prescription Drugs - NYSHIP Health Plan		
NYSHIP	877-769-7447	www.cs.ny.gov
Prescription Drugs - Aetna Health Plan		
CVS Caremark	855-296-7683 (TTY:711)	www.caremark.com
Dental		
CIGNA Dental Care (DHMO) **OR** CIGNA DPPO	800-578-5682	www.cigna.com
Vision		
EyeMed	800-334-7591	www.eyemedvisioncare.com
Union		
SSSA	718-858-2113	N/A
TSO	718-601-8900	N/A
Federal Programs		
Medicare	800-633-4227	www.MyMedicare.gov
Social Security Administration	800-772-1213	www.ssa.gov
Business Service Center		

Phone: 646-376-0123, 8:30 a.m. - 5 p.m., Monday – Friday
Email: bscservice@mtabsc.org
Website: www.mymta.info

Please have your BSC ID ready when you call us and be sure to include your full name and BSC ID on all emails and documents.

Notice of Creditable Coverage
If you or your family members are not currently covered by Medicare and will not be covered by Medicare in the next year, this notice does not apply to you.

Important Notice from New York City Transit (NYCT) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with New York City Transit and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. NYCT has determined that the prescription drug coverage we offer is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year thereafter during the open enrollment period. For 2024, the open enrollment period will be from October 15 through December 7, 2023.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, you will still be eligible to receive retiree medical and prescription coverage. However, NYCT's plan will pay secondary to Medicare.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with NYCT and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact information is provided below if you need further information.

NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through NYCT changes. You also may request a copy of this notice at any time.

MTA Business Service Center:
Call: 646-376-0123 (8:30 a.m. – 5:00 p.m., Monday through Friday)
Fax: 212-852-8700
Email: bscservice@mtabsc.org

For More Information about Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

EMPLOYEE OR RETIREE AFFIDAVIT

STATE OF: _____

COUNTY OF: _____ **DATE:**_____

NAME [ ] BSC ID # [ ]
being duly sworn, deposes and says:

1. I am an employee of or have retired from [circle appropriate agency]
   New York City Transit Authority MaBSTOA SIRTOA MTA BUS Co.

2. I make this affidavit based on personal knowledge and under penalties of perjury.

3. My spouse [PRINT NAME], _____,
   is currently <u>not</u> covered by my health insurance as a dependent on my plan.

4. I am unable to provide a copy of the top half of the front page of my most recent federal tax return that includes my spouse (with financial information blacked out); and the E-File confirmation page, Tax Preparer's Summary, or the Federal Return Recap; nor can I provide any of the following alternate documentation of joint ownership, dated no earlier than twelve (12) months prior to my application for coverage for my spouse:

   - Homeowners/Renters Insurance Policy
   - Credit Card Statement
   - Loan Obligation or Bank Account Statement
   - Pension/Life Insurance/a Will designating your spouse as beneficiary
   - Mortgage Statement/Rental/Lease Agreement or Property Tax Document
   - Utility/phone/internet/cable bills

Despite my inability to produce any of the necessary documentation, I hereby affirm, under penalties of perjury, that my spouse and I are currently married and that we are not legally separated or divorced.

PRINT EMPLOYEE OR RETIREE NAME

Sworn to before me this

_____ day of_____ 20____
Date Month Year

_____

SIGNATURE OF EMPLOYEE OR RETIREE

NOTARY PUBLIC

_____

13333090

2024 Health Plan Highlights for SSSA/TSO Operating & Queens Division/TSO MSII/MTA Bus TSO Local 106 Active Employees

MEDICAL	AETNA CPOS II Basic OPTION	AETNA SELECT OPTION	NYSHIP Empire Plan PPO	NYSHIP Emblem Health HMO
Medical Benefits	In-Network and Out-of-Network Benefits	In-Network Benefits **ONLY**	In-Network and Out-of-Network Benefits	In-Network Benefits **ONLY**
Annual Medical Deductible	$0 In-Network $100 Out-of-Network	$0: In-Network Benefits **ONLY**	$0: In-Network $1,250: Combined Out-of-Network Deductible (Indivdual or Family)	$0: In-Network Benefits **ONLY**
Out-of-Pocket Maximum	No Out-of-Pocket Maximum	No Out-of-Pocket Maximum	$3,200 for Rx Drug Pgm: In-Network Annual Out-of Pocket Maximum (Does **not** apply to Medicare-primary Enrollees) $5,900 Shared Maximum for Hospital, Medical/Surgical, & Mental Health/Substance Use Pgms (Individual Coverage) $6,400 for Rx Drug Pgm: In-Network Annual Out-of Pocket Maximum $11,800 Shared Maximum for Hospital, Medical/Surgical, & Mental Health/Substance Use Pgms (Family Coverage)	In-Network **ONLY** Annual Out-of Pocket Maximum: $6,850 Individual/Year $13,700 Family/Year
Primary Care Physician (PCP) Referral Requirement	No Referrals Required	No Referrals Required	No Referrals Required	Referrals Required
Annual Preventative Care Visits				
Annual Physical Exams, Well-Woman Visits, & Routine Immunizations & Diagnostic Screenings	$0 Copay: In-Network Based on Allowance Schedule: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$0 Copay: In-Network Annual Deductible and/or Coinsurance Applies: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**
Routine Well-Child Exams & Immunizations (Up to Age 19)	$0 Copay: In-Network Based on Allowance Schedule: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$0 Copay: In-Network Annual Deductible and/or Coinsurance Applies: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**
Office Visits (Outside of Routine Annual Preventative Care Visits)				
Primary Care & Specialist Office Visits	$15 Copay: In-Network Based on Allowance Schedule: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$25 Copay: In-Network Primary & Specialist Visits Annual Deductible and/or Coinsurance Applies: Out-of-Network	$5 Copay: In-Network Primary Care Visits **ONLY** $10 Copay: In-Network Specialist Visits **ONLY**
Hospital Services				
In-patient Hospital Deductible	$50/Confinement Per Person (100% Covered After Deductible Met) $240/Per Family Maximum Per Calendar Year	No Deductible (Services Covered At 100%)	No Deductible (Pre-admission Certification Required)	No Deductible (Services Covered At 100%)
Outpatient Hospital Deductible	Included in Medical Deductible (100% Covered After Deductible Met)	No Deductible (Services Covered At 100%)	No Deductible $95 Copay/Visit for In-Network Hospitals **|** $50 for Participating Providers $25 Copay/Visit for Participating Provider Offices	No Deductible (Services Covered At 100%)
Emergency Room Services	$100 Copay (Waived if admitted to hospital)	$100 Copay (Waived if admitted to hospital)	$100 Copay (Waived if admitted to hospital)	$75 Copay (Waived if admitted to hospital)
Urgent Care Services	$15 Copay: In-Network $15 Copay: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$30 Copay/Visit: In-Nework Urgent Care Facility $50 Copay/Visit: In-Network Hospital-owned Urgent Care Facilty Annual Deductible and/or Coinsurance Applies: Out-of-Network	$25 Copay: In-Network Benefits **ONLY**
Family Planning Services	$15 Copay: In-Network Based on Allowance Schedule: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$0 Copay: In-Network Annual Deductible and/or Coinsurance Applies: Out-of-Network	In-Network Benefits **ONLY**: $5 Copay: Primary Care Visits **|** $10 Copay: Specialist Visits
Chiropractic Care	$15 Copay with Unlimited Visits & Pre-certification Required After 20th Visit: In-Network Based on Allowance Schedule: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$25 Copay: In-Network Annual Deductible and/or Coinsurance Applies: Out-of-Network	$10 Copay: In-Network Specialist Visits **ONLY**
Physical Therapy	$15 Copay: In-Network Based on Allowance Schedule: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$25/Copay: In-Network $250 Annual Deductible & 50% Coinsurance: Out-of-Network	In-Network Benefits **ONLY**: $0 Copay: Inpatient Care (30 Day Max) **|** $5 Copay: Outpatient Care $10 Copay: Outpatient Specialist (90 Visit Max on Outpatient Rehab)
Durable Medical Equipment	**Expenses Vary Based on DME Type:** $100 Deductible/Person per Calendar Year: In-Network $100 Deductible/Person per Calendar Year & 50% Coinsurance Plus any Amt Billed Above Allowed Amt: Out-of-Network	In-Network Benefits **ONLY** $100 Deductible/Person per Calendar Year	$0 Copay: In-Network Cost Based on DME Type: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**
Mental Health & Alcohol/Substance Abuse Services				
Mental Health Inpatient Services	$50/Confinement Per Person ($240/Family Max Per Calendar Year): In-Network Based on Allowance Schedule: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$0 Copay: In-Network Facility $1,250 Combined Out-of-Network Annual Deductible (Indivdual or Family) & 90% Coinsurance: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**
Mental Health Outpatient Services	$15 Copay: In-Network Based on Allowance Schedule: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$25 Copay: In-Network Practitioner $1,250 Combined Out-of-Network Annual Deductible (Indivdual or Family) & 80% Coinsurance: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**
Alcohol/Substance Abuse Inpatient Services	$50/Confinement Per Person ($240/Family Maximum Per Calendar Year): In-Network Based on Allowance Schedule: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$0 Copay: In-Network $1,250 Combined Out-of-Network Annual Deductible (Indivdual or Family) & 90% Coinsurance: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**
Alcohol/Substance Abuse Outpatient Services	$15 Copay: In-Network Based on Allowance Schedule: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$25/Day: In-Network (Approved Intensive Outpatient Programs) $1,250 Combined Out-of-Network Annual Deductible (Indivdual or Family) & 80% Coinsurance: Out-of-Network	$5 Copay: In-Network Benefits **ONLY**
Autism Spectrurm Disorder Care				
	$15 Copay: In-Network Physical/Occupational Therapy and Speech/Language Therapy (Unlimited Visits **|** Medical Necessity Review Conducted After 20 Visits) Based on Allowance Schedule: Out-of-Network	In-Network Benefits **ONLY**: $0 Copay: In-Network Physical/Occupational Therapy and Speech/Language Therapy (90 Visit Maximum per Calendar Year)	$25 Copay: Applied Behavioral Analysis (ABA) Therapy for Autism (Pre-certification Required) NYSHIP's Medical/Surgical and/or Mental Health & Substance Abuse (MHSA) Programs Cover Majority Of Autism Care, Including Assessments, Evaluations, or Tests to Diagnose Autism Spectrum Disorder (ASD), Medications, Assistive Communication Devices, Psychological, Psychiatric, & Therapeutic Care, Inclusive of Services Provided by Licensed Speech Therapists, Occupational Therapists, Social Workers, & Physical Therapists	In-Network Benefits **ONLY**: $10 Copay: Applied Behavioral Analysis (ABA) Therapy for Autism NYSHIP's Medical/Surgical and/or Mental Health & Substance Abuse (MHSA) Programs Cover Majority Of Autism Care, Including Assessments, Evaluations, or Tests to Diagnose Autism Spectrum Disorder (ASD), Medications, Assistive Communication Devices, Psychological, Psychiatric, & Therapeutic Care, Inclusive of Services Provided by Licensed Speech Therapists, Occupational Therapists, Social Workers, & Physical Therapists
PRESCRIPTION DRUGS				
Retail: 30-Day Supply				
Generic	$0 Copay	$0 Copay	$5 Copay	$5 Copay
Formulary Brand	$20 Copay	$20 Copay	$30 Copay	$20 Copay
Non-Formulary Brand	$40 Copay	$40 Copay	$60 Copay	N/A
Mail Order: Up to 90 Day Supply *Mail Order is MANDATORY*				
Generic	$0 Copay	$0 Copay	$10 Copay	$7.50 Copay
Formulary Brand	$40 Copay	$40 Copay	$60 Copay	$30 Copay
Non-Formulary Brand	$80 Copay	$80 Copay	$120 Copay	N/A
Specialty Medication Mail Order: 31-to-90-day Supply via Mail Service or Designated Specialty Pharmacy				
Generic	N/A	N/A	$5 Copay	N/A
Preferrred Brand	N/A	N/A	$55 Copay	N/A
Non-Preferrred Brand	N/A	N/A	$110 Copay	N/A

2024 Open Enrollment/Change Form

For Active NYCT SSSA/TSO Operating & Queens Division/TSO MSII/MTA Bus TSO Local 106 Employees

HR-BEN-810K

Section 1 - Information and Instructions

Complete this form to enroll in **or** change your health insurance coverage. This form is only for Active NYCT SSSA/TSO Operating & Queens Division/TSO MSII/MTA Bus TSO Local 106 employees and/or their dependent(s).

It is important to complete **ALL** applicable sections of this form. You **MUST** submit a new request if there are any changes in the below information. Completed and signed forms may be submitted via fax to 212-852-8700 **OR** via email to BSC-Benefits@mtabsc.org.

If you have questions, contact the Business Service Center (BSC) at 646-376-0123, 8:30AM - 5:00PM, Monday to Friday **OR** BSCService@mtabsc.org.

Section 2 - Employee Information

Print Name	Last	First	M.I.	BSC ID#
Phone (Cell)		Phone (Home)		E-Mail

Your health insurance cards will be mailed to the address on your pay stub. If your address is incorrect, please log onto www.mymta.info to update your address or to obtain the *HR-HRIS-012 Employee Data Change Form*. An incorrect address will delay receipt of your new health insurance cards.

Section 3 - Medical and Dental Coverage Election (Effective January 1, 2024)

MEDICAL: Individual ☐ Family ☐

Check only **ONE**:

☐ **AETNA CPOS II BASIC OPTION**

☐ **AETNA SELECT OPTION** (National provider network allows you to see Aetna participating providers within the United States)

MTA MEDICAL OPT-OUT PROGRAM

☐ **I WISH TO ENROLL IN THE MTA MEDICAL OPT-OUT PROGRAM FOR MEDICAL, HOSPITAL, AND PRESCRIPTION DRUG COVERAGE**

I agree to the terms and conditions of the Medical Opt-Out Program detailed in Section 7 of this form. Proof of alternate medical enrollment **MUST** be provided below.

Name of Policyholder: _____	Relationship to Policyholder: _____
Employer of Policyholder: _____	Date of Birth of Policyholder: _____
Name of Insurance Carrier: _____	SSN of Policyholder: _____
Policy Number: _____	

DENTAL: Individual ☐ Family ☐

Check only **ONE** of the following dental plans: ☐ **CIGNA Dental Care (DHMO)** ☐ **CIGNA DPPO Dental**

Section 4 - Dependent Information

ADD, REMOVE, OR CHANGE DEPENDENT(S):

Please fill in all information for dependents you wish to add (enroll), remove (delete), or change, and submit the required documentation (see Section 6 of this form). Use a separate sheet if more space is needed. Failure to submit required documentation will result in your request **NOT** being processed.

If you are found to be covering an ineligible dependent, coverage will be terminated retroactive to the date of the ineligibility and New York City Transit (NYCT) will pursue financial restitution for claims and/or premiums for the ineligible dependent(s).

DOMESTIC PARTNER:

Please contact the MTA Business Service Center for the Domestic Partnership Package if you wish to enroll a domestic partner. Your domestic partner will **not** be enrolled in health coverage unless a Domestic Partner Package is submitted and approved by the Benefits Department. If you are *removing* a Domestic Partner, please complete and submit this open enrollment/change form along with the Termination of Domestic Partnership Form.

Indicate (A) Add, (R) Remove, or (C) Change					Relationship (Check only ONE)			Gender			Date of Birth		
A	R	C	Full Name	SSN	Spouse	Domestic Partner*	Child	F	M	X	MM	DD	YYYY

Section 5 - Signature and Authorization

I do hereby certify that to the best of my knowledge, the above information is true and correct. My signature and date on this form certifies and warrants all dependent eligibility information is true, correct, and current. I also certify that dependent children from age 19 to 26 I have enrolled are eligible for MTA-sponsored coverage.

Employee Signature:	**Date:**

2024 Open Enrollment/Change Form

For Active NYCT SSSA/TSO Operating & Queens Division/TSO MSII/MTA Bus TSO Local 106 Employees

HR-BEN-810K

Section 6 - Required Supporting Documentation

1. **For a Spouse:**
   A copy of your Marriage Certificate, Birth Certificate, and Social Security Card are **required**. In place of the required Birth Certificate, any one (1) of the following official government documents can be alternatively submitted:
   - Letter from Social Security Administration containing your spouse's date of birth
   - Valid US Passport **or** Resident Alien Card
   - Valid Driver's License (New York)
   - Public Assistance ID Card
   - Government Employment ID

   AND

   If your date of marriage is more than one (1) year old, proof of joint ownership is also required. If your marriage date is less than 1 year old, such proof is not required. **If removing a spouse due to divorce, submit the first and last page of the divorce decree showing the court filing date.**

   Both the enrollee's and spouse's name must be listed on the documentation of joint ownership. Where indicated, proof***** of joint ownership must be dated within the past 90 days. Examples of proof of joint ownership include a copy of:
   - Most recent tax return showing "Married Filing Jointly" or "Married Filing Separately". Your spouse's name **must** appear on the tax form on the line after the "Married Filing Separately" status (or vice versa). Submit page 1 of tax return.
   - Homeowners/Renters Insurance Policy
   - Credit Card Statement*****
   - Loan Obligation or Bank Account Statement*****
   - Pension or Life insurance or Will, designating your spouse as a beneficiary
   - Mortgage Statement or Rental/Lease Agreement or Property Tax Document*****
   - Utility or Phone or Internet/Cable Bill*****

   If you are not able to provide the required documentation, please complete the Employee/Retiree Affidavit, have it notarized, and return it with your completed enrollment form.

2. **For Children:**
   For a Natural-Born Child, a copy of:
   - Birth Certificate showing employee's name*****
   - Social Security Card

   For a Stepchild or Legally Adopted Child, a copy of:
   - Birth Certificate*****
   - Social Security Card
   - Legal documentation concerning adoption/guardianship

***Due to Puerto Rico's Birth Certificate Law, Puerto Rican Birth Certificates issued prior to July 1, 2010 are invalid, and will not be accepted.**

Section 7 - MTA Medical Opt-Out Program Terms and Conditions

MTA MEDICAL OPT-OUT PROGRAM INCENTIVE:
You may opt-out of medical coverage and receive a lump-sum incentive payment. Opting out of medical coverage means that you elect *not* to participate in MTA-sponsored **medical, hospital, and prescription drug coverage**. You will however retain coverage in the dental and vision plans.

To be eligible for the Medical Opt-Out Program, you **must** document you will be covered by another medical plan sponsored by:
- A spouse or domestic partner's employer
- Another employer
- The Armed Forces

LUMP-SUM INCENTIVE PAYMENT: Payment of the lump-sum incentive will be made at the *end* of the opt-out year **or** the *beginning* of the next calendar year following the opt-out year, based on union affiliation

Active SSSA (except SSSA Confidential) & MTA Bus TSO Local 106 Employees: If you participate in the Opt-Out Program and separate from MTA service *before* the end of the opt-out year, you will **not** be eligible to receive any part of the below incentive payment.
- **$550** for employees receiving medical coverage via a spouse/domestic partner also employed by NYCT or another MTA agency
- **$550** for employees who opt out of *INDIVIDUAL* medical coverage
- **$1,100** for employees who opt out of *FAMILY* medical coverage

Active SSSA Confidential, TSO Operating & Queens Division/TSO MSII Employees: If you participate in the Opt-Out Program and separate from MTA service *before* the end of the opt-out year, the incentive payment will be pro-rated based on the months of enrollment in the Opt-Out Program.
- **$1,000** for employees receiving medical coverage via a spouse/domestic partner also employed by NYCT or another MTA agency
- **$1,000** for employees who opt out of *INDIVIDUAL* medical coverage
- **$3,000** for employees who opt out of *FAMILY* medical coverage

TERMS OF AGREEMENT:
I understand this election will be effective from January 1 - December 31, 2024, unless I am no longer allowed by law or as a result of a qualifying event or such other events as the Authority determines will permit a change or revocation of an election. I understand the lump-sum payment will be subject to all applicable federal, state, and local taxes. I also understand that these monies will *not* be considered income for pension purposes and will *not* be included in any calculation therein. This agreement is subject to the terms of the employer's plan in effect and as amended from time to time and shall be governed by and construed in accordance with applicable laws. This agreement shall take effect as a sealed instrument under applicable laws and revokes any prior election and compensation agreement relating to such plan. The health benefits waiver (opt-out) will be administered as permissible under IRS Section 125.

2024 NYSHIP Open Enrollment/Change Form
HR-BEN-060K

NEW YORK STATE OF OPPORTUNITY. **Department of Civil Service**

EMPLOYEE BENEFITS DIVISION
NYSHIP Health Insurance Transaction Form
for NYS & PE Employees
PS-404 (1/2023)

INSTRUCTIONS: READ AND COMPLETE BOTH PAGES. PLEASE PRINT, CHECK THE APPROPRIATE CHOICES AND SIGN/DATE THE DOCUMENT.

EMPLOYEE INFORMATION

1. Last Name / First Name / MI		**2.** Social Security Number	**3.** Gender ☐ F ☐ M ☐ X
4. Permanent Address Street	City	State	Zip
5. Mailing Address (If different) Street	City	State	Zip
6. Work Location & Address Street	City	State	Zip
7. Date of Birth	**8.** Telephone Numbers Primary ( )	Work ( )	
9. Personal Email Address			
10. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated		Marital Status Date	
11. Covered under Medicare? ☐ Self	Medicare ID Number: _____	Date: _____	
☐ Dependent	Medicare ID Number: _____ Dependent Name: _____	Date: _____	
12. Is any of this information new? ☐ No ☐ Yes	Box Number(s): _____	Effective Date of Change: _____	

13. ENTER REQUEST(S) BELOW:

A. Pre-Tax Election

1. ☐ **Elect Pre-Tax Status** for Premium deduction

B. Elect a NYSHIP Coverage Option Below (You can ONLY choose ONE option between either 1 or 2)

1. Request Individual Enrollment	Medical *(10)* *(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO Code ☐ Name _____	
2. Request Family Enrollment *(Must complete Box 14 below)*	Medical *(10)* *(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO Code ☐ Name _____	
3. Medical Opt-out Program	You can only enroll in the Medical Opt-Out program during the annual Open Enrollment Period. Please complete the HR-BEN-036 Agreement to Decline (Opt-Out) Medical Coverage form OR visit My MTA Portal at **www.mymta.info** to easily opt out on-line.	

14. ENTER DEPENDENT INFORMATION:

MUST be provided when choosing to enroll or cancel NYSHIP family coverage *(use additional sheets if necessary)*

Check ONE: A (Add), D (Delete) or C (Change)
ONLY M (Medical) is applicable
Date of Event: _____

↓	↓	Last Name	First Name	MI	Relationship	Date of Birth	Gender	Address *(if different)*	Social Security Number
☐ A ☐ D ☐ C	☐ M						☐ F ☐ M ☐ X		
☐ A ☐ D ☐ C	☐ M						☐ F ☐ M ☐ X		
☐ A ☐ D ☐ C	☐ M						☐ F ☐ M ☐ X		

2024 NYSHIP Open Enrollment/Change Form
HR-BEN-060K

Department of Civil Service
Albany, NY 12239

NYSHIP Health Insurance Transaction Form
PS-404 (1/2023)

15. ENTER ELECTION CHANGE(S) BELOW:

A. CHANGE Coverage: ☐ Medical *(10)* **Date of Event:** _____

☐ **Change to FAMILY Coverage** *(Must complete Box 14 on Page 1)* ☐ **Change to INDIVIDUAL Coverage**

- ☐ Marriage
- ☐ Domestic Partner
- ☐ Newborn
- ☐ Request coverage for dependents not previously covered
- ☐ Previous coverage terminated *(proof required)*
- ☐ Dependent returned to full-time student status
- ☐ Other: _____

- ☐ Divorce
- ☐ Termination of Domestic Partnership *(Attach completed PS-425.4)*
- ☐ Only dependent ineligible due to age
- ☐ I voluntarily cancel coverage for my dependents
- ☐ Only dependent died
- ☐ Only dependent graduated
- ☐ Other: _____

NOTE: If you are indicating a change in marital status to Divorced or Separated, please be sure to update the address information for the dependent in box 14 if applicable.

B. Voluntarily Decline or Cancel Coverage: ☐ Medical *(10)* **Qualifying Event:** _____

*(If currently enrolled in coverage & you would like to voluntarily **CANCEL** your coverage, please indicate the qualifying event above.)*

Personal Privacy Protection Law Notification

The information you provide on this application is requested in accordance with Section 163 of the New York State Civil Service Law for the principal purpose of enabling the Department of Civil Service to process your request concerning health insurance coverage. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may interfere with our ability to comply with your request. This information will be maintained by the Director, Employee Benefits Division, Department of Civil Service, Albany, NY 12239; (518) 473-1977. For information relating only to the Personal Privacy Protection Law, call (518) 457-9375.

AUTHORIZATION

I have read the Pre-Tax Contribution Program materials and the Opt-out Attestation Form (if applicable) and have made my selection on Page 1 of this document. I understand that if my coverage is declined or canceled, I may subject myself and/or my dependents to waiting periods if I decide to enroll at a later date and may forfeit the right to such coverage after leaving State service (vest, retirement, etc.). I am aware of how to obtain a current *Summary of Benefits and Coverage* for the NYSHIP option I have selected. I understand that my failure to provide required proof(s) within 30 days may delay the availability of benefits for me or any dependent for whom I fail to provide such proof. Any person who makes a material misstatement of fact or conceals any pertinent information shall be guilty of a crime, conviction of which may lead to substantial monetary penalties and/or imprisonment, as well as an order for reimbursement of claims.
I certify that the information I have supplied is true and correct. I hereby authorize deduction from my salary or retirement allowance of the amount required, if any, for the coverage indicated above.

Employee Signature (Required): _____ **Date:** _____

AGENCY USE ONLY

Retirement Tier	Registration #	Sick Leave Information # Hours	Sick Leave Information Hourly Rate of Pay	Date Entered on NYBEAS	Effective Date

HBA Signature (Required): _____ **Date:** _____

2024 NYSHIP Open Enrollment/Change Form
HR-BEN-060K

Department of Civil Service
Albany, NY 12239

Instructions for NYSHIP Health Insurance Transaction Form
for NYS & PE Employees PS-404 (1/2023)

NYSHIP Program Information Resources

To enroll in benefits or to change your current benefits, you will be required to submit proofs of eligibility for coverage or evidence of a qualifying event with the completed and signed NYSHIP *Health Insurance Transaction Form* PS-404. Learn more about these additional requirements in the following publications:

- ***General Information Book (GIB):*** Eligibility, enrollment, required forms and proofs of eligibility
- ***Planning for Option Transfer:*** The Pre-Tax Contribution Program (PTCP)
- ***Choices:*** Your plan options under NYSHIP (Empire Plan, NYSHIP HMO or the Opt-out Program) and the benefits included with each one

In many situations, you will also be required to complete, sign and submit additional forms and proofs. For detailed instructions on what will be required, please refer to your *GIB* and any additional forms and form instructions for requirements specific to your request.

Please return this completed form and all required supporting documentation to the MTA Business Service Center (BSC) via email at BSC-Benefits@mtabsc.org or via fax to 212-852-8700.

EMPLOYEE INFORMATION

Boxes 1 – 12	Employee Information	You must complete boxes 1 – 11 with your personal information. In Box 12, indicate if any of the information in Boxes 1 – 11 is new and needs to be undated on your NYSHIP record. Please also indicate which of the boxes contains updated information and a date of the change (if applicable). **Note:** Use the Marital Status Date to show the date of marriage, separation, or divorce when any of those marital statuses are selected.
Boxes 13 (A-B)	Elect Coverage	You can only select one (1) between Option 1 (Request Individual Enrollment) **OR** Option 2 (Request Family Enrollment) in Section B. You can **ONLY** enroll in the Medical Opt-Out Program during the annual Open Enrollment Period. Newly hired employees **MUST** wait until their respective Open Enrollment Period to enroll in the opt-out program. In order to opt-out, do **NOT** complete this form. Instead, during your Open Enrollment Period, you **MUST** complete the **HR-BEN-036 Agreement to Decline (Opt-Out) Medical Coverage Non-Represented & Eligible Represented Employees** form OR visit My MTA Portal at **www.mymta.info** to easily opt out on-line.

ELECT COVERAGE

Note: If you choose a NYSHIP HMO, the HMO may require you to complete an additional enrollment form.

13.A.1 13.A.2	Pre-Tax Contribution Program (PTCP) Status	The PTCP applies to all NYS groups and select Participating Employers (PE).
13.B.1	Request Individual Enrollment	Check box to enroll in Individual Coverage.
13.B.2	Request Family Enrollment	Check box to enroll in Family Coverage.
13.B.3	Medical Opt-out Program	To participate in Medical Opt-Out, do **NOT** complete this form. You **MUST** visit **My MTA Portal** to opt out online OR complete HR-BEN-036 Opt-Out form during your Open Enrollment Period.

2024 NYSHIP Open Enrollment/Change Form
HR-BEN-060K

Department of Civil Service
Albany, NY 12239

Instructions for NYSHIP Health Insurance Transaction Form
for NYS & PE Employees PS-404 (1/2023)

DEPENDENT INFORMATION

Box 14	Dependent Information	Check the box to add or delete a dependent or to change a dependent's information. Check the Medical box as the coverage being changed. Complete all dependent information and provide the dependent's Social Security Number. Additional documentation is required to add dependent(s).

CHANGE COVERAGE OR VOLUNTARILY DECLINE/CANCEL COVERAGE

Box 15.A	Change Coverage	Check this box to change from Individual to Family or from Family to Individual coverage. If you are enrolled in PTCP, you may only change coverage from Family to Individual during the applicable annual open enrollment period or within 30 days of a PTCP qualifying event (check the qualifying event and enter the Date of Event). Check the Medical box as the coverage being changed. In the event that you are indicating a change in your marital status to divorced or separated, please update the dependent's new address, if applicable, in the Dependent Information section (Box 14).
Box 15.B	Voluntarily Decline or Cancel Coverage	You are entitled to voluntarily ***Decline*** coverage if you are a newly hired employee *OR* promoted into an eligible role/title. Due to a qualifying life event *OR* during your respective open enrollment period, you are eligible to voluntarily ***Cancel*** your current enrollment/coverage.

AUTHORIZATION	You must SIGN and DATE this form.

2024 Dental Open Enrollment/Change Form

For Active NYCT SSSA/TSO Operating & Queens Division/TSO MSII/TSO SSII/MTA Bus TSO Local 106/Special Inspector (UFLEO) Employees with NYSHIP Health Plan

HR-BEN-810N

Section 1 - Information and Instructions

Complete this form to enroll in **or** change your dental insurance coverage.

This form is **only** for Active NYCT SSSA/TSO Operating & Queens Division/TSO MSII/TSO SSII/MTA Bus TSO Local 106/Special Inspector (UFLEO) employees and/or their dependent(s) who are *enrolled in or will be enrolling in the NYSHIP Health Plan*.

Do **NOT** complete this form if you are currently enrolled in or will be enrolling in one of the available Aetna plans for your medical coverage. For TSO SSII and Special Inspector (UFLEO) employees, please do **NOT** submit this form if you are making your dental plan changes online.

It is important to complete **ALL** applicable sections of this form. You **MUST** submit a new request if there are any changes in the below information.

Completed and signed forms may be submitted via fax to 212-852-8700 **OR** via email to BSC-Benefits@mtabsc.org.

If you have questions, contact the Business Service Center (BSC) at 646-376-0123, 8:30AM - 5:00PM, Monday to Friday **OR** BSCService@mtabsc.org.

Section 2 - Employee Information

Print Name	Last	First	M.I.	BSC ID#
Phone (Cell)		Phone (Home)		E-Mail

If your address is incorrect, please log onto www.mymta.info to update your address or to obtain the *HR-HRIS-012 Employee Data Change Form*. An incorrect address will delay the receipt of important plan enrollment confirmation info.

Section 3 - Dental Coverage Election (Effective January 1, 2024)

DENTAL: Individual ☐ Family ☐

Check only **ONE** of the below dental plans:

☐ **CIGNA Dental Care (DHMO)**

☐ **CIGNA DPPO Dental**

Section 4 - Dependent Information

ADD, REMOVE, OR CHANGE DEPENDENT(S):
Please fill in all information for dependents you wish to add (enroll), remove (delete), or change, and submit the required documentation (see Section 6 of this form). Use a separate sheet if more space is needed. Failure to submit required documentation will result in your request **NOT** being processed.

If you are found to be covering an ineligible dependent, coverage will be terminated retroactive to the date of the ineligibility and New York City Transit (NYCT) will pursue financial restitution for claims and/or premiums for the ineligible dependent(s).

DOMESTIC PARTNER:
Please contact the MTA Business Service Center for the Domestic Partnership Package if you wish to enroll a domestic partner. Your domestic partner will **not** be enrolled in dental coverage unless a Domestic Partner Package is submitted and approved by the Benefits Department. If you are *removing* a Domestic Partner, please complete and submit this dental open enrollment/change form along with the Termination of Domestic Partnership Form.

Indicate (A) Add, (R) Remove, or (C) Change					Relationship (Check only ONE)			Gender			Date of Birth		
A	R	C	Full Name	SSN	Spouse	Domestic Partner*	Child	F	M	X	MM	DD	YYYY

Section 5 - Signature and Authorization

I do hereby certify that to the best of my knowledge, the above information is true and correct. My signature and date on this form certifies and warrants all dependent eligibility information is true, correct, and current. I also certify that dependent children from age 19 to 26 I have enrolled are eligible for MTA-sponsored coverage.

Employee Signature:	**Date:**

2024 Dental Open Enrollment/Change Form

For Active NYCT SSSA/TSO Operating & Queens Division/TSO MSII/TSO SSII/MTA Bus TSO Local 106/Special Inspector (UFLEO) Employees with NYSHIP Health Plan

HR-BEN-810N

Section 6 - Required Supporting Documentation

1. **For a Spouse:**
   A copy of your Marriage Certificate, Birth Certificate, and Social Security Card are **required**. In place of the required Birth Certificate, any one (1) of the following official government documents can be alternatively submitted:
   - Letter from Social Security Administration containing your spouse's date of birth
   - Valid US Passport **or** Resident Alien Card
   - Valid Driver's License (New York)
   - Public Assistance ID Card
   - Government Employment ID

   AND

   If your date of marriage is more than one (1) year old, proof of joint ownership is also required. If your marriage date is less than 1 year old, such proof is not required. **If removing a spouse due to divorce, submit the first and last page of the divorce decree showing the court filing date.**

   Both the enrollee's and spouse's name must be listed on the documentation of joint ownership. Where indicated, proof***** of joint ownership must be dated within the past 90 days. Examples of proof of joint ownership include a copy of:
   - Most recent tax return showing "Married Filing Jointly" or "Married Filing Separately". Your spouse's name **must** appear on the tax form on the line after the "Married Filing Separately" status (or vice versa). Submit page 1 of tax return.
   - Homeowners/Renters Insurance Policy
   - Credit Card Statement*****
   - Loan Obligation or Bank Account Statement*****
   - Pension or Life insurance or Will, designating your spouse as a beneficiary
   - Mortgage Statement or Rental/Lease Agreement or Property Tax Document*****
   - Utility or Phone or Internet/Cable Bill*****

   If you are not able to provide the required documentation, please complete the Employee/Retiree Affidavit, have it notarized, and return it with your completed enrollment form.

2. **For Children:**
   For a Natural-Born Child, a copy of:
   - Birth Certificate showing employee's name*****
   - Social Security Card

   For a Stepchild or Legally Adopted Child, a copy of:
   - Birth Certificate*****
   - Social Security Card
   - Legal documentation concerning adoption/guardianship

***Due to Puerto Rico's Birth Certificate Law, Puerto Rican Birth Certificates issued prior to July 1, 2010 are invalid, and will not be accepted.**

Agreement to Decline (Opt-Out) Medical Coverage
Non-Represented and Eligible Represented Employees

HR-BEN-036

Section 1 - Information and Instructions

The purpose of this form is to decline MTA sponsored benefits coverage. Unless otherwise stated, the MTA Business Service Center (BSC) will assume that each year you would like to continue your opt-out agreement, and will never request this form again. If you wish to enroll in MTA Benefits coverage during any point of your tenure with the MTA, you will only be able to do so during the open enrollment period, or a qualifying life event.

Please email completed form to bscservice@mtabsc.org.or fax to 212-852-8700.

If you have any questions, please contact the Business Service Center (BSC) at 646-376-0123 or bscservice@mtabsc.org.

Section 2 - Employee Information

Print Name	Last		First		M.I. Suffix	BSC ID
Agency/Dept. (check one)	☐ BSC	☐ B&T	☐ CC	☐ HQ	☐ NYCT	Department
	☐ SIR	☐ LIRR	☐ MNR	☐ MTA Bus	☐ MABSTOA	
Street Address						
City					State	Zip Code
Phone (H)			Phone (W)			Email

Section 3 – Incentive Selection

*Select the option that will be applicable for the entire year of **20**____*

INITIAL YOUR SELECTION

☐ I am an employee who receives medical coverage through my spouse/domestic partner who is also employed by the Metropolitan Transportation Authority or another MTA agency, and I, therefore, decline health coverage. Incentive for this option is **$1,000 or $550**. Payment will occur after the end of the plan year.

☐ I am an employee without dependent(s) declining individual coverage. Incentive for this option is **$1,000 or $550**. Payment will occur after the end of the plan year.

☐ I am an employee with dependent(s) declining family coverage. Incentive for this option is **$3,000 or $1,100**. Payment will occur after the end of the plan year.

Note: If you have previously waived coverage or you do not currently have dependent coverage, you must provide documentation for dependents in order to opt out of family coverage. See the enrollment form for details.

Section 4 – Medical Coverage Information

*Provide the information relative to the medical plan that you will be enrolled in for the year **20**____*

Name of Insurance Company:	Plan Sponsor (Employer):
Name of Policyholder:	Relationship:

Section 5 – Medical Coverage Information

I understand that this election will be effective from January 1 through my tenure with the MTA, unless I am no longer allowed by law or as a result of a qualifying event or such other events as the Authority determines will permit a change or revocation of an election. I understand that the lump sum payment will be subject to all applicable federal, state and local taxes. I also understand that these monies will not be considered income for pension purposes and will not be included in any calculation therein.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S PLAN, AS AMENDED FROM TIME TO TIME IN EFFECT, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION AGREEMENT RELATING TO SUCH PLAN. THE HEALTH BENEFITS WAIVER WILL BE ADMINISTERED AS PERMISSIBLE UNDER IRC SECTION 125.

Employee Signature	Date	SSN Last 4 Digits

2024 Medical Opt-Out Lump Sum Deferral Form

HR-DEFCOMP-075

Section 1 - Information and Instructions

This form is for the **2024** Opt-Out Program. **It must be completed each year**. Medical Opt-Out deferral elections do not carry over year-to-year. Non-represented employees will be paid in **January 2025**; represented employees will be paid the in **December 2024** or pursuant to your collective bargaining agreement.

The Medical Opt-Out payment will be included in your regular paycheck and will not be a separate paycheck. If you elect to defer money from your Medical Opt-Out payment into your 401(k) or 457 Plan, you will need to elect a dollar amount that includes both the amount you want withheld for the medical opt-out payment as well as your regular deferral.

THE AMOUNT ELECTED BELOW WILL BE SET UP TO OVERRIDE YOUR REGULAR DEDUCTION, SO PLEASE TAKE THAT INTO CONSIDERATION WHEN MAKING YOUR ELECTION.

FOR EXAMPLE, IF YOU REGULARLY DEFER $100 FROM YOUR WEEKLY OR BI-WEEKLY PAY INTO YOUR 401(K) PLAN, AND YOU WANT TO DEFER $1,000 FROM THE MEDICAL OPT-OUT PAYMENT, YOUR ELECTION ON THIS FORM WOULD NEED TO BE $1,100.

Also note that that FICA taxes are required to be withheld from your full gross payment even if you are electing to defer into the 401(k)/457 Plans. 401(k) and 457 deferrals are only pre-tax for federal and state tax purposes.

Submit this form to the MTA Business Service Center: Email (preferred): bscservice@mtabsc.org; Fax: 212-852-8700. If you have any questions, please contact the BSC at 646-376-0123.

Section 2 - Employee Information

Print Name	Last		First		M.I. Suffix	BSC ID
Agency/Dept. (check one)	☐ BSC	☐ B&T	☐ C&D	☐ HQ	☐ Police	Department
	☐ SIR	☐ MNR	☐ MTA Bus	☐ NYCT	☐ MaBSTOA	
Street Address						
City				State		Zip Code
Phone (H)		Phone (W)		Email		

Section 3 – Allocation to Deferred Compensation Plans

	Fixed Dollar Amount ($)
401(k) Plan	
401(k) Roth Plan	
457 Plan	
457 Roth Plan	

Section 4 - Authorization

*I authorize the MTA to reduce my medical opt-out lump sum payment by the deferral amounts listed above. I understand that these deferrals are subject to IRS limits for each calendar year and that this payment is a part of my W-2 wages and therefore subject to certain required tax withholdings as described in Section 1 of this form. Finally, I acknowledge that this signed form must be received by the MTA **at least one month prior to the date the medical opt out will be paid**. Forms signed or received after the payment has been made will not be honored*

Employee Signature:	Date:	SSN Last 4 Digits