# 2025 Open Enrollment

# October 15 - November 15, 2024

# Health Benefits Summary

## New York City Transit
## TWU Local 100 and MTA Bus TWU Local 100
## 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.

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# 1 INTRODUCTION

## Open Enrollment Period: October 15 - November 15

***Plan changes will be effective January 1, 2025***

### 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
- Self-service access to change plan enrollments
- Summary of Health Benefits
- Medical enrollment/change forms
- Flexible Spending Account enrollment information
- Opt-Out Program brochure and form

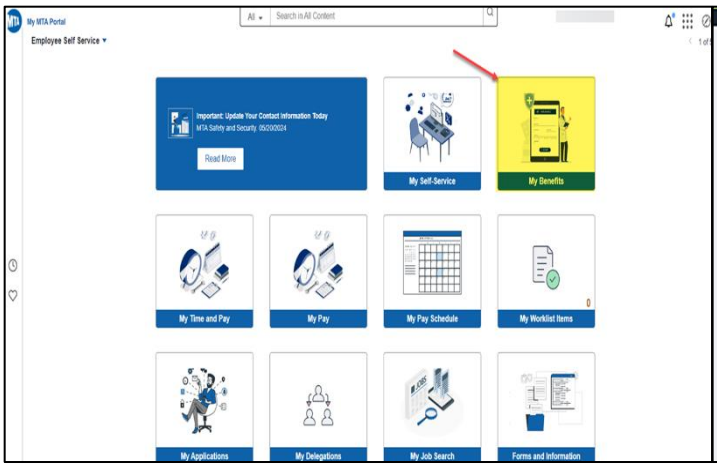
### Dates to remember…

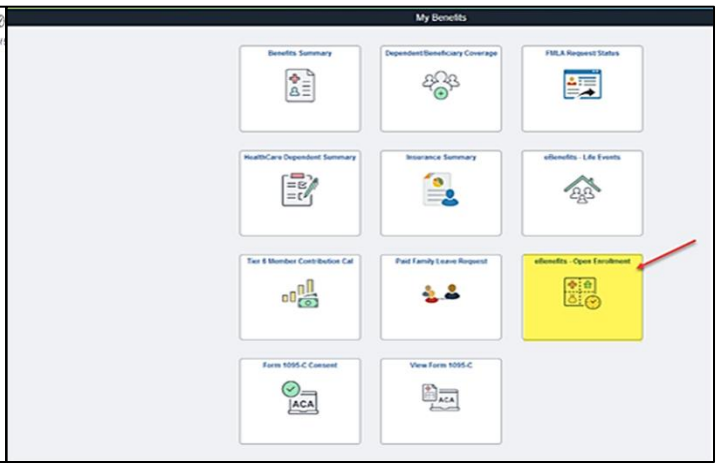
You can access information on the MTA Opt-Out and Tax-Favored programs via the BSC website and the provider websites. Go to www.mymta.info/openenrollment.

- **Medical Opt-Out Program: October 15 - November 15**
- Flexible Spending Account (FSA): November 1 - December 15

# 2 HOW TO MAKE CHANGES

- **To make medical plan changes online:**
  - Sign on to the My MTA Portal (www.mymta.info)
  - On the home page, click the **My Benefits** tile, then click the **eBenefits - Open Enrollment** tile

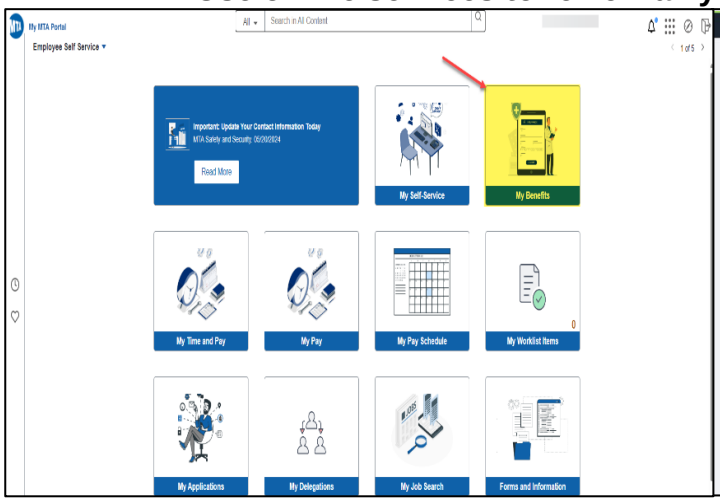


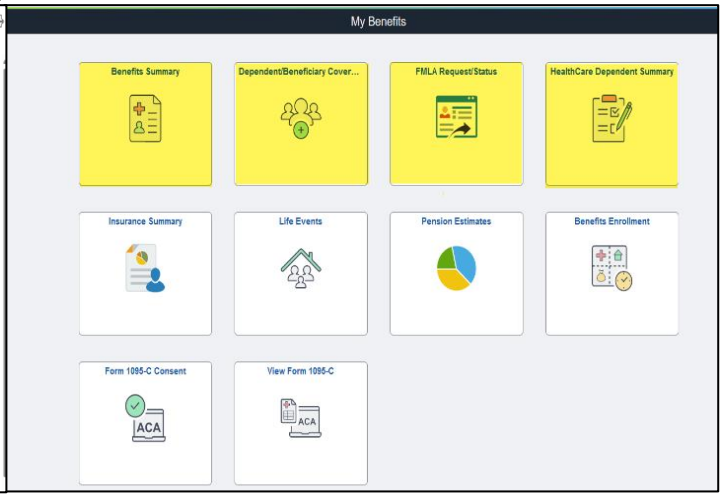




- **To make medical plan changes via form and/or to <u>add a *new* dependent</u>**, submit the below enrollment form:
  - **HR-BEN-849A** Health Plan Open Enrollment/Change Form for Active NYCT TWU Local 100 & MTA Bus TWU Local 100 Employees

  - *Do **<u>NOT</u>** use/submit the form listed above if you're making your changes online*

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



# 3 HEALTH BENEFIT CHOICES

## Electing or Changing Medical/Dental/Vision Coverage

| Medical/Hospital | Prescription Drugs | Dental | Vision |
|---|---|---|---|
| Aetna CPOS II Basic Option | CVS Caremark | TWU Local 100 | TWU Local 100 |
| Aetna CPOS II High Option* | CVS Caremark | EmblemHealth Preferred Dental | TWU Local 100 |
| Aetna Select Option (National provider network allows you to see Aetna participating providers within the United States) | CVS Caremark | TWU Local 100 | TWU Local 100 |

***If you elect to dis-enroll from the Aetna CPOS II High Option, you will NOT be able to re-enroll in this plan for two years.**

## Medical Plan Options

**January 1, 2025 Aetna Options for Active TWU Local 100 and MTA Bus TWU Local 100 Represented Members**

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

| Benefit | | Aetna CPOS II Basic or High Option 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 |
| Autism Spectrum Disorder: | - Applied Behavioral Analysis (ABA) | $0 copay (Requires Pre-certification) | $0 copay (Requires Pre-certification) |
| | - Behavioral/Physical/Occupational & Speech Therapy Sessions | $0 copay (Unlimited Sessions) | $0 copay (Unlimited Sessions) |

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

## Note to All Employees Planning to Retire in 2025

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 your 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 the Aetna Medicare Advantage Options 1 or 2.

## Value-Added Benefits

Along with your enrollment in any of the Aetna health plans, also comes added benefits such as:

| Value Added Benefits | Aetna CPOS II Basic or High Option | 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 or High Option | 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.

## Dental and Vision Plan Options

| DENTAL | (Contact TWU Local 100 except for Aetna CPOS II High Option Members who **MUST** contact the MTA BSC or EmblemHealth Preferred Dental) | **EmblemHealth Preferred Dental** (This is the **only** dental choice for those enrolled in the Aetna High Option Plan) |
|---|---|---|
| Type of Plan | | PPO In-Network & Out-Of-Network |
| | | **In-Network Highlights** |
| Deductible | | $50 per person per year |
| Annual Maximum | | $1,200 |
| Orthodontics to Age 19 | | $1,500 Lifetime Max |
| Oral Examination & Diagnosis | | Covered in Full |
| X-Rays | | Covered in Full |
| Fluoride Treatment | | Covered in Full |
| Filling | | 80% |
| Root Canal | | 80% |
| Crowns & Bridges | | 50% |

| VISION | Contact TWU Local 100 |
|---|---|

## Dependent Coverage

| Dependent Coverage | | |
|---|---|---|
| **Age when dependent coverage ends:** | **Age 21** | **Age 26** |
| **MEDICAL/HOSPITAL** | | |
| Aetna Basic, Aetna High, and Aetna Select Options | N/A | End of Month |
| **PRESCRIPTION DRUGS** | | |
| CVS Caremark | N/A | End of Month |
| **DENTAL** | | |
| **MUST** Contact TWU Local 100 | | |
| EmblemHealth Preferred Dental (**ONLY if Aetna High Option Plan is Selected**) | End of Month | N/A |
| **VISION** | | |
| **MUST** Contact TWU Local 100 | | |

***Please Note:* Full-time Student Status Verification is not required.**

# 4 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 2024 and wish to continue in the Opt-Out Program for 2025:**
   - **NO ACTION REQUIRED:** Your opt-out status will remain in place for 2025

2. **If you previously enrolled in the Opt-Out Program in 2024 and wish to *re-enroll* in Medical/Hospital and Prescription Drug Coverage for 2025, you MUST:**
   - Complete the **HR-BEN-849A** Health Plan Open Enrollment/Change Form for Active NYCT TWU Local 100 & MTA Bus TWU Local 100 Employees, and submit to the BSC, **by November 15, 2024**

3. **If you are currently enrolled in Medical/Hospital and Prescription Drug Coverage for 2024 and wish to *enroll* in the Medical Opt-Out Program for 2025, you MUST:**
   - Complete the ***Opt-Out Program* section** on the **HR-BEN-849A** Health Plan Open Enrollment/Change Form for Active NYCT TWU Local 100 & MTA Bus TWU Local 100 Employees, and submit to the BSC, **by November 15, 2024**

### 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, 2025

2. The incentive payments for individual or family plan opt-out will be paid in December 2025 **OR** pursuant to the represented employee's collective bargaining agreement
   - **For 2025, the individual opt-out incentive payment is $550**
   - **For 2025, the family opt-out incentive payment is $1,100**

3. Active employees must opt-out for the entire calendar year to receive the full incentive payment. If you 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

4. You have the option to defer the 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**

5. 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)

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

7. If you *waived* or *declined* health plan coverage as a new hire in 2024 and wish to now enroll in the Opt-Out Program for 2025, you **MUST** submit a request to opt-out during your respective Open Enrollment period

8. 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

# 5 LEGAL REQUIREMENTS

## Coverage for Dependent Children

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

EmblemHealth Preferred Dental coverage ends at age 21.

- To enroll a dependent child, age 19 to 26, submit the **HR-BEN-849A** Health Plan Open Enrollment/Change Form for Active NYCT TWU Local 100 & MTA Bus TWU Local 100 Employees

Submit the form detailed above 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 the 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 the enrollment form listed below.

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

- **HR-BEN-849A** Health Plan Open Enrollment/Change Form for Active NYCT TWU Local 100 & MTA Bus TWU Local 100 Employees.

# 6 IMPORTANT TELEPHONE NUMBERS & WEBSITES

| | | |
|---|---|---|
| **Medical/Hospital** | | |
| Aetna CPOS II Basic **OR** Aetna High **OR** Aetna Select Options | 855-824-5349 | www.aetnaNYCT.com |
| Aetna 24/7 Health Line | 800-556-1555 (TTY:711) | www.aetnaNYCT.com |
| **Prescription Drugs** | | |
| CVS Caremark | 855-296-7683 (TTY:711) | www.caremark.com |
| **Dental (Aetna High Option Plan ONLY)** | | |
| EmblemHealth Preferred Dental in New York City Area | 212-501-4444 | www.emblemhealth.com |
| EmblemHealth Preferred Dental Outside of New York City Area | 800-624-2412 | www.emblemhealth.com |
| EmblemHealth Preferred Dental Hearing Impaired | TTY/TDD:711 | www.emblemhealth.com |
| **Union** | | |
| TWU Local 100 | 212-873-6000 | www.twulocal100.org |
| **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, 8:30a.m. - 5p.m., Monday - Friday<br>Email: bscservice@mtabsc.org<br>Website: www.mymta.info<br><br>***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 2025, the open enrollment period will be from October 15 through December 7, 2024.

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 an alternate Medicare drug plan, your MTA-sponsored medical and prescription drug coverage will be automatically terminated.

## 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 [check 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 _____

# Health Plan Open Enrollment/Change Form

For Active NYCT TWU Local 100 & MTA Bus TWU Local 100 Employees

**HR-BEN-849A**

## Section 1 - Information & Instructions

Complete this form to enroll in **or** change your health insurance coverage. This form is only for Active NYCT TWU Local 100 **and** MTA Bus TWU Local 100 employees and/or their dependent(s). Do **NOT** submit this form if you are making your plan enrollment 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 **must** be submitted via fax to 212-852-8700 **OR** via email to bsc-benefits@mtabsc.org for processing.

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

## Section 2 - Employee Information

| Print Name | Last | First | M.I. | BSC ID# |
|---|---|---|---|---|
| Phone (Cell) | | Phone (Home) | | Personal 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 Coverage Election (Effective January 1, 2025)

**MEDICAL:** Individual ☐ Family ☐

Check only **ONE**:

☐ **AETNA CPOS II BASIC OPTION**

☐ **AETNA CPOS II HIGH OPTION** (Includes EmblemHealth Preferred Dental Coverage)

- ✓ **Required** bi-weekly, pre-tax contribution of $13.17 for Individual Coverage and $26.34 for Family Coverage
- ✓ Dependent children, regardless of full-time student status, are only eligible for dental coverage through the end of the month they attain age 21

☐ **AETNA SELECT OPTION** (National **in-network only** providers: Allows you to see Aetna *participating* providers within the United States)

**You MUST direct questions about dental, vision, and other benefits to your respective union.**

### 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: _____

Employer of Policyholder: _____

Name of Insurance Carrier: _____

Policy Number: _____

Relationship to Policyholder: _____

Date of Birth of Policyholder: _____

SSN of Policyholder: _____

## Section 4 - Dependent Information

**ADD, REMOVE, OR CHANGE DEPENDENT(S):**

Please complete all information for dependents you wish to add (enroll), remove (delete), or change. The required supporting documentation (see Section 6 of this form) is only required if you are adding a new dependent, removing a spouse due to divorce, or changing a current dependent's biographical information. Use a separate sheet if more space is needed to list additional dependents.

For **Newborns:** Supporting documentation is **required** within ninety (90) days of a newborn's birth to remain enrolled in MTA-sponsored benefits. Failure to provide all required documentation within this timeframe will result in the retro-termination (to date of birth) of the newborn from your health coverage.

For **Divorce:** Supporting documentation is **required** within thirty-one (31) days of the divorce date to remove an ex-spouse from health coverage.

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 paid 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 enrollment/change form along with the **required** NYCT 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 |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |

# Health Plan Open Enrollment/Change Form

For Active NYCT TWU Local 100 & MTA Bus TWU Local 100 Employees

**HR-BEN-849A**

## Section 5 - Signature & 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 all dependent children I have enrolled, including those aged 19 to 26, are eligible for MTA-sponsored coverage.*

| **Employee Signature:** | **Date:** |
|---|---|

## Section 6 - Required Supporting Documentation

1. **For a Spouse:**
   A copy of your official governmental (non-religious) Marriage Certificate (religious documents will **not** be accepted), spouse's Birth Certificate, and spouse's 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
   - 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 filed by the County Clerk's Office.**

   **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 as applicable.

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 incentive payment. To be eligible for the 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; or the Armed Forces.

**LUMP-SUM INCENTIVE PAYMENT:**
Payment of the lump-sum incentive will be made at the *end* of the opt-out year as indicated below:
- **$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

**TERMS OF AGREEMENT:**
I understand this election will be effective from January 1 - December 31, 2025, 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.

# 2025 Medical Opt-Out Lump Sum Deferral Form

HR-DEFCOMP-075

## Section 1 - Information and Instructions

This form is for the **2025** 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 2026**; represented employees will be paid in **December 2025** 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 |