2023 Open Enrollment
October 15 - November 15, 2022
Health Benefits Summary

New York City Transit
SSSA/TSO Operating/Special Inspectors
Active Employees
with TWU Local 100 Medical Benefits

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, 2023

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 Informational Sessions
- 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 **My Benefits**
  - Then click **eBenefits - Open Enrollment**

- **To make medical plan changes via form and/or to <u>add a *new* dependent</u>:**
  - Submit **HR-BEN-370B** 2023 Open Enrollment/Change Form Active SSSA/TSO Operating/Special Inspector Employees with TWU L100 Medical Benefits
  - *Do **<u>NOT</u>** use/submit the above form if you are making your changes online*

- **To change information or remove a current dependent:**
  - Submit **HR-BEN-600** Dependent Change Form
  - *You **<u>cannot</u>** make dependent changes online. You must access the form from the eBenefits - Open Enrollment ribbon or go to the 2023 Open Enrollment website at: www.mymta.info/openenrollment*

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

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3 HEALTH BENEFIT CHOICES

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 CPOS II High Option*	CVS Caremark	EmblemHealth Preferred Dental	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

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

Medical Plan Options

January 1, 2023 Aetna Options for Active TWU L100/ATU 726/ATU 1056/SIRTOA SMART 1440 & SSSA with TWU L100 Medical Benefits/SSSA/TSO Operating/SPI with TWU L100/ATU 726/ATU 1056 Medical Benefits/MTA Bus Represented (Except Spring Creek L1181) 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	100% coverage
Substance abuse:	- Office visit	$15 copay	100% coverage
	- Inpatient	100% coverage	100% coverage

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

Note to All Employees Planning to Retire in 2023

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.

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 CPOS II Basic Option and Aetna Medicare Advantage Options 1 or 2.

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
Disease 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 Plans

DENTAL	Cigna DPPO Dental		Cigna Dental Care (DHMO)	EmblemHealth Preferred Dental (this is only dental choice for those enrolled in High Option medical plan)
Network Access	DPPO In-Network Network	DPPO Out-of-Network	DHMO	PPO In-Network and Out-of-Network
	In- Network Highlights	Out-of-Network Highlights	In -Network Only	In- Network Highlights
Deductible	$0	$0	$0	$50 per person, per year
Annual Maximum	$2,500 Indv/$5,000 Fam	$2,500 Indv/$5,000	$2,500 Indv/ $5,000 Fam	$1,200
Orthodontics up to age 23, if banded up to age 26	$0	100% of schedule amount	$0 Copay	$1,500 lifetime max
Oral Examination & Diagnosis	$0	100% of schedule amount	$0 Copay	Covered in full
X-Rays	$0	100% of schedule amount	$0 Copay	Covered in full
Fluoride Treatment	$0	100% of schedule amount	$0 Copay	Covered in full
Filling	$0	100% of schedule amount	$0 Copay	80%
Root Canal	$0	100% of schedule amount	$0 Copay	80%
Crowns and Bridges	$0	100% of schedule amount	$0 Copay	50%

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/High Option 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
EmblemHealth Preferred Dental	N/A	End of Month	N/A	N/A
VISION				
Vision Plan	N/A	N/A	N/A	End of Month

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 2022 and wish to continue in the Opt-Out Program for 2023:**
   - **NO ACTION REQUIRED:** Your opt-out status will remain in place for 2023
2. **If you previously enrolled in the Opt-Out Program in 2022 and now wish to *re-enroll* in Medical/Hospital and Prescription Drug Coverage for 2023, you MUST:**
   - Complete an **HR-BEN-370B** 2023 Open Enrollment/Change form, and submit to the BSC, **by November 15, 2022**

3. **If you were previously enrolled in Medical/Hospital and Prescription Drug Coverage for 2022 and now wish to *enroll* in the Medical Opt-Out Program for 2023, you MUST:**
   - Complete the ***Opt-Out Program* section** on the **HR-BEN-370B** 2023 Open Enrollment/Change form, and submit to the BSC, **by November 15, 2022**

Additional Information about the Medical Opt-Out Program:

1. To opt-out of medical/hospital and prescription drug coverage, you ***must*** provide proof that you have coverage under an alternate medical plan or will have coverage by January 1, 2023

2. The incentive payments for individual or family plan opt-out will be paid during the last pay period in January 2024 **OR** pursuant to the represented employee's collective bargaining agreement
   - **For 2023, the individual opt-out incentive payment is $550**
   - **For 2023, 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 service before the end of the year, the incentive payment will be prorated

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 **annually**

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. If you are a ***non-represented*** employee currently contributing toward your medical coverage, no contributions will be withheld from your 2023 salary if you participate in the Opt-Out Program

7. If you are 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 2022 and wish to enroll in the Opt-Out Program for 2023, 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

5 LEGAL REQUIREMENTS

Grandfathered Status

NYC Transit's health plans are "grandfathered" under the Affordable Care Act (ACA). As permitted by the ACA, grandfathered health plans can preserve certain basic benefits that were already in effect when the law was enacted. Grandfathered status also means that our plans may not include certain consumer protections of the ACA that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the ACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the BSC via email to bscservice@mtabsc.org or by calling the BSC Customer Management Center at 646-376-0123.

Coverage for Dependent Children Ages 19 to 26

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-370B 2023 Open Enrollment/Change** form

- To remove or change a CURRENT dependent child (age 19 to 26) on your health insurance, submit the **HR-BEN-600 Dependent Change Request** form

Submit the applicable form with the required documentation listed on the back of the form, 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 **My Benefits**, then click **Health Care Dependent Summary.** 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 a copy of the dependent's Social Security Card with your name and BSC ID number noted on the copy, along with the **HR-BEN-600 Dependent Change Request** form to the BSC. Be sure to include your name and BSC ID number on the copy of the Social Security Card as well.

6 IMPORTANT TELEPHONE NUMBERS & WEBSITES

Medical/Hospital		
Aetna CPOS II Basic/High Option	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
Prescription Drugs		
CVS Caremark	855-296-7683 (TTY:711)	www.caremark.com
Dental		
CIGNA Dental Care (DHMO) **or** CIGNA DPPO	800-578-5682	www.cigna.com
Dental (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
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 2023, the open enrollment period will be from October 15 through December 7, 2022.

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

2023 Open Enrollment/Change Form

Active SSSA/TSO Operating/Special Inspector Employees with TWU L100 Medical Benefits

HR-BEN-370B

Section 1 - Information and Instructions

Use this form to enroll/change health insurance **OR** make your plan change online at www.mymta.info > **My Benefits>eBenefits – Open Enrollment.** **DO NOT SUBMIT THIS FORM IF YOU ARE MAKING YOUR PLAN ENROLLMENT CHANGE ONLINE.**

To remove/change current dependent information only, use **HR-BEN-600 Dependent Change Request Form**.

Please return the completed, signed form by: Email: bsc-benefits@mtabsc.org **OR**

Fax: 212-852-8700

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

Section 2 - Employee Information

Print Name	Last	First	M.I.	Suffix	BSC ID
					Pass #
Phone (H)		Phone (W)			Email

If your address on your pay stub is incorrect, contact the BSC OR log onto www.mymta.info **change your address online OR complete HR-HRIS-012 Employee Data Change Form. An incorrect address will delay receipt of your new health insurance cards.**

Section 3 - Coverage Election (Effective January 1, 2023)

Medical ☐ Individual ☐ Family

Check **One**

☐ **AETNA CPOS II BASIC OPTION**

☐ **AETNA CPOS II HIGH OPTION** **- (includes EmblemHealth Preferred Dental)
(Bi-weekly pre-tax required contribution of $13.17 for Individual Coverage and $26.34 for Family Coverage)

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

**** If you did not choose AETNA CPOS II HIGH OPTION, please direct questions about dental and vision coverage to your union.***

☐ **OPT-OUT PROGRAM (for Medical/Hospital/Prescription Drugs)**

I agree to the Terms and Conditions of the Opt-Out Program on the back of this form. ***Alternate medical information must be provided below.***

Name of Policyholder: _____ Relationship: _____

Policy #: _____ SS# of Policyholder: _____

Name of Insurance Carrier: _____ Date of Birth of Policyholder: _____

Employer of Policyholder: _____

Dental ☐ Individual ☐ Family

Check **one** of the following dental plans **ONLY** if you did not enroll in the **High Option**, which includes dental coverage.

☐ **Cigna DPPO Dental**

☐ **Cigna Dental Care (DHMO)**

Section 4 - Dependent Information

If you are found to be covering an ineligible dependent, coverage will be terminated retroactive to the date of the ineligibility and NYC Transit will pursue financial restitution for claims and/or premiums for the ineligible dependent.

ADD/REMOVE/CHANGE DEPENDENT(S)

Please fill in all information for dependents you wish to add/remove/change and submit **required** documentation (see Section 6). Documentation must be received by the BSC within 90 days from the effective date of coverage. Failure to submit documentation will result in termination of your dependent's coverage.

DOMESTIC PARTNER

Please contact the 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 an application is submitted and approved by the Benefits Department.
If you are removing a Domestic Partner, please complete and submit this form along with the Domestic Partnership Termination form.

Check One - Indicate (A) Add (R) Remove (C) Change					Check One - Relationship			Gender		Date of Birth		
A	R	C	Name	SSN	Spouse	Domestic Partner	Child	F	M	Mo	Day	Year

Section 5 - Authorization

My signature and date on this form certifies and warrants that all dependent eligibility information is true, correct, and current. I also certify that dependent children from age 19 to 26 that I have enrolled in coverage are eligible for coverage.

Employee Signature	**Date**

Business Service Center
Last Revised: 10/15/2022

Creation Date: 04/01/2012

2023 Open Enrollment/Change Form

Active SSSA/TSO Operating/Special Inspector Employees with TWU L100 Medical Benefits

HR-BEN-370B

Section 6 - Dependent Required Documentation

1. **For a Spouse**

A copy of your Marriage Certificate, Birth Certificate, and Social Security Card are required.

In place of required Birth Certificate, any of the following official government documents can be submitted:

- Valid Drivers' License-New York
- Resident Alien Card
- Valid US Passport
- A letter from Social Security containing your date of birth
- Public Assistance ID Card
- Government Employment ID Card

If your date of marriage is more than one year old, proof of joint ownership is also required.

Both the enrollee's and spouse's names must be listed on the documentation of joint ownership. Where indicated, proof* must be dated within the past 90 days. Any financial information or account numbers can be removed.
Examples include a copy of:

- Your 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 provided after the "married filing separately" status (or vice versa). Submit page 1 of the tax return.
- 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

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

2. **For Children**

For a Natural-Born Child, a copy of:

- Birth Certificate showing employee's name
- Social Security Card
- Puerto Rican Birth Certificates issued prior to July 1, 2010 are unacceptable

For a Stepchild or Legally Adopted Child, a copy of:

- Birth Certificate
- Social Security Card
- Legal documentation concerning adoption

3. **Dependent Children (between ages 19 and 26)**

- To enroll a dependent child from age 19 to 26 in your medical, hospital, and prescription drug coverage, add the child's name on this form, submit required documentation, and affirm by signing this form that your child is not eligible for other employer-sponsored coverage.
- Those who enrolled in the High Option are not required to submit student verification from age 19 to 21 to cover dependent children in dental coverage.
- To continue covering a dependent child from age 19 to 25 on dental (except High Option), you are required to submit a full-time student verification letter. Students will also be entitled to vision coverage under EyeMed.

Section 7 - Opt-Out Program Terms and Conditions

Incentive for Opt-Out

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 medical, hospital, and prescription drug coverage. You will however retain coverage in dental and vision plans. To be eligible, you must document that you will be covered by another medical plan sponsored by:

- a spouse or domestic partner's employer
- another employer
- armed forces

Lump Sum Incentive Payment

Payment of the lump sum incentive will be made at the end of the Opt-Out year in the following amount:

- **$550** for an employee who receives medical coverage through spouse/domestic partner who is also employed by NYC Transit or another MTA agency
- **$550** if you opt-out of *individual* medical coverage
- **$1,100** if you opt-out of *family* medical coverage

If you participate in the Opt-Out Program and either re-enroll or retire during that same year, you will not be eligible to receive any part of the incentive payment.

Terms of Agreement

I understand that this election will be effective from January 1 through December 31, 2022, 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 IRS section 125.

Dependent Change Request Form

HR-BEN-600

Section 1 - Information and Instructions

The purpose of this form is to remove or change CURRENT dependents ONLY on your health insurance.

If you need to add a NEW dependent, please contact BSC to obtain the correct form.

Please submit a signed copy of this form with required documentation (see page 2, section 6) via:

Fax: 212-852-8700

Email: BSC-benefits@mtabsc.org

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.		BSC ID
			Pass #
Street Address		Apt #	
City		State	Zip Code
Phone (H)	Phone (W)	Phone (M)	Email

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 – Coverage Election

Please indicate the plan(s) you are updating for your CURRENT dependent(s).

☐ **MEDICAL** ☐ **DENTAL** ☐ **VISION** ☐ **LIFE INSURANCE**

Section 4 – CURRENT Dependent Information

REMOVE OR CHANGE CURRENT DEPENDENTS ONLY

Please fill in all information for any CURRENT dependent(s) you wish to remove or change and submit Required Documentation (see Section 6-Documentation). Failure to submit required documentation will result in your request **NOT** being processed.

DOMESTIC PARTNER

Please contact the 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 an application is submitted and approved by the Benefits Department.

If you are disenrolling a Domestic Partner, please complete and submit this form along with the Domestic Partnership Termination form.

Check One: Indicate (R) Remove OR (C) Change				Relationship: Check one			Gender		Date of Birth		
R	C	Name	SSN	Spouse	Domestic Partner	Child	F	M	Month	Day	Year

Section 5 - 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 that all dependent eligibility information is true, correct and current. I also certify that dependent children from age 19 to 26 that I have enrolled in coverage are not eligible for another employer sponsored coverage.

Employee Signature	Date

Dependent Change Request Form

HR-BEN-600

Section 6 – Required Documentation

FOR NYCT PLANS:

1. For a Spouse

   A copy of Marriage Certificate, Birth Certificate, and Social Security card are required.

   In place of a required Birth Certificate, any of the following official government documents can be submitted.

   - Any other official Government documents are:
     - A letter from Social Security containing your spouse's date of birth
     - Valid US Passport
     - Valid Driver's License-New York
     - Resident Alien Card
     - Public Assistance ID Card
     - Government Employment ID

2. For Children
   - For a Natural-Born Child, a copy of:
     - Birth Certificate showing employee's name
     - Social Security Card
     - Due to Puerto Rico's Birth Certificate Law, Puerto Rican Birth Certificates issued prior to July 1, 2010 are invalid and therefore not acceptable.

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

FOR ALL NYSHIP PLANS:

1. For a Spouse

   A copy of Marriage Certificate, Birth Certificate, and Social Security card are required. In place of a required Birth Certificate, a passport may be accepted.

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

AND

FOR ALL PLANS:

If your date of marriage is more than one year old, proof of joint ownership is also required.

Please submit one of the documents below in addition to your required documents. Both the employee and spouse's name must be listed on the documentation of joint ownership. Where indicated, proof***** must be dated within the past 90 days. Examples include a copy of:

- Your 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 provided after the "married filing separately" status (or vice versa). Submit page 1 of the tax return.
- Homeowners/Renters Insurance Policy
- Credit Card Statement*****
- Loan Obligation or Bank Account Statement*****
- Pension/life insurance/will, designating your spouse as beneficiary
- Mortgage Statement /Rental/Lease Agreement or Property Tax Document*****
- Utility/phone/internet/cable bills*****

If you are removing a spouse due to divorce, please submit the first and last page of your divorce decree showing the court filing date.

2023 Medical Opt-Out Lump Sum Deferral Form

HR-DEFCOMP-075

Section 1 - Information and Instructions

The Medical Opt-Out payment will be included in with your regular paycheck and will not be a separate paycheck. The deferral amount you elect below will override your regular (weekly or bi-weekly) deferral election, whether that is a dollar amount or a percentage. 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.

Please note that FICA taxes are required to be withheld from your full gross payment even if you are electing to defer into the 401(k) or 457 Plan. These 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

This form is for the 2023 Opt-Out Program. The form must be completed each year you want to make a Medical Opt-Out deferral. Medical Opt-Out deferral elections do not carry over year-to-year.

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 amount 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.

Non-represented employees will be paid in January 2024; represented employees will be paid the in December 2023 or pursuant to your collective bargaining agreement.

This form must be sent to the Business Service Center at least one month prior to the date the medical opt out will be paid.

Employee Signature:	Date:	SSN Last 4 Digits