2024 Open Enrollment

November 1 - December 31, 2023

Health Benefits Summary

MTA
Metro-North Railroad (MNR)

MTA Business Service Center
www.mymta.info

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Attachments:
- HR-BEN-060K 2024 NYSHIP Open Enrollment/Change Form
- HR-BEN-622E 2024 ConnectiCare Open Enrollment/Change Form
- HR-BEN-036 Agreement to Decline (Opt-Out) Medical Coverage Non-Represented & Eligible Represented Employees
- HR-DEFCOMP-075 2024 Medical Opt-Out Lump Sum Deferral Form

1 INTRODUCTION

Open Enrollment Period: November 1 – December 31

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

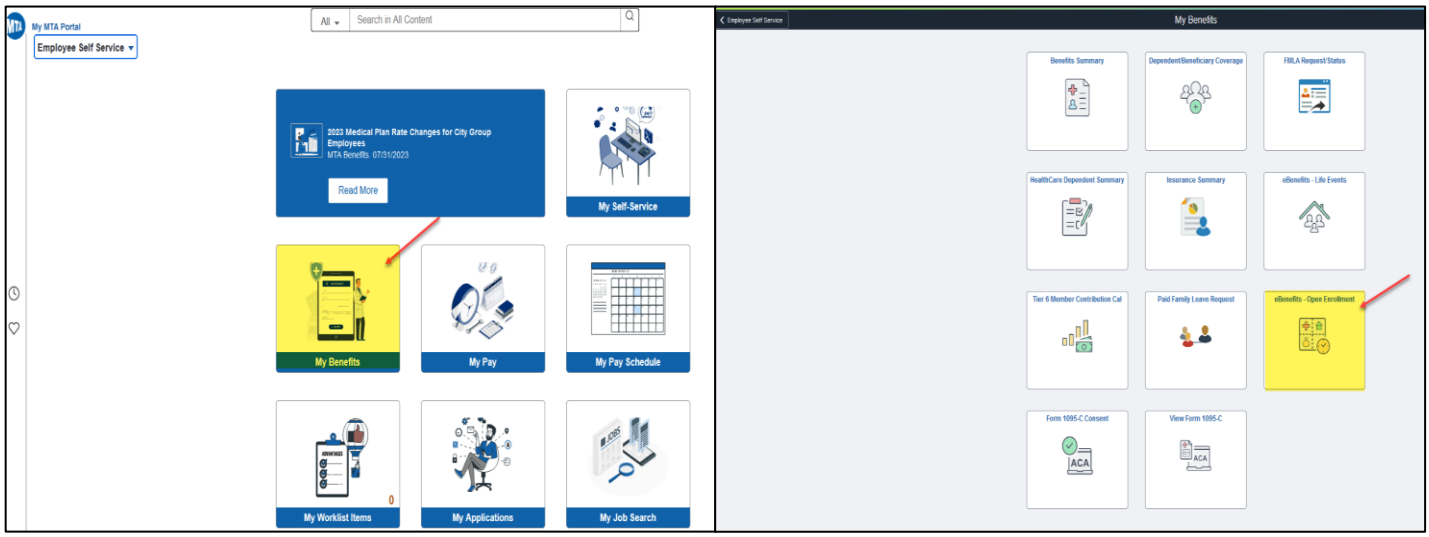
Dates to remember…

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: November 1 - December 31**
- Flexible Spending Account (FSA): November 1 - December 15

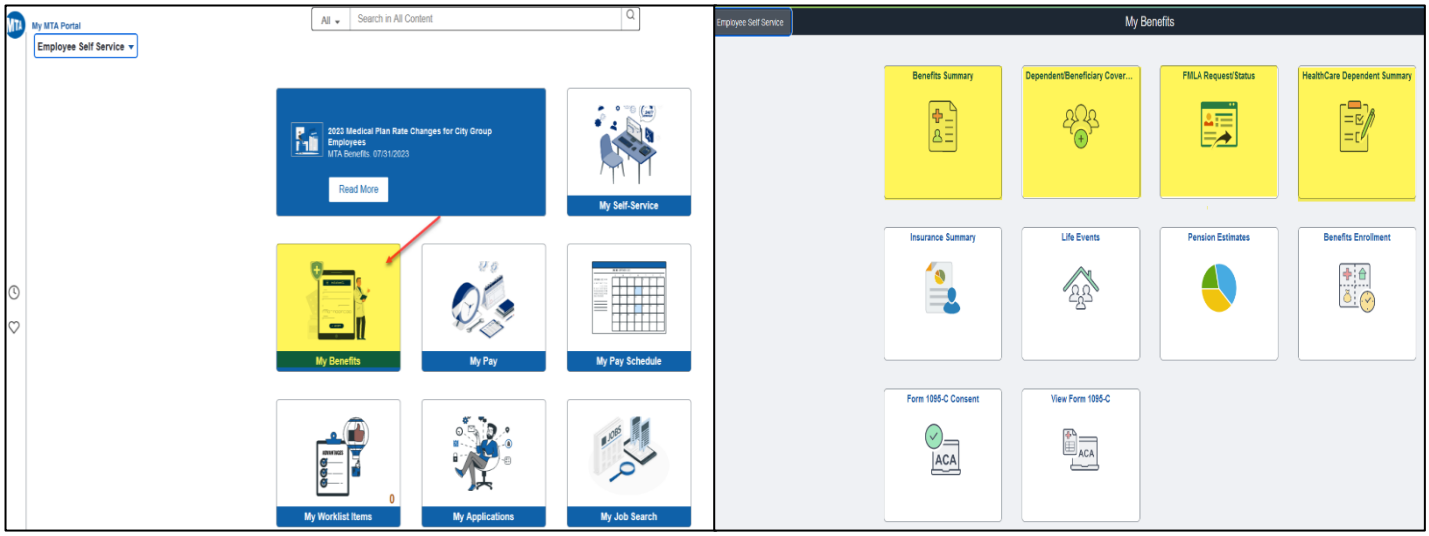
2 HOW TO MAKE CHANGES

- **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 the **eBenefits - Open Enrollment** tile



- **To make medical plan changes via form <u>OR</u> *add, remove, or change a dependent***, you must submit the **HR-BEN-060K** 2024 NYSHIP Open Enrollment/Change Form
  - Dependent updates **<u>cannot</u>** be submitted online
  - You **<u>MUST</u>** submit the above form if you would like to add a new dependent *<u>or</u>* remove or make changes to your current dependent information
  - *Do **<u>NOT</u>** use/submit the above form if you are making your <u>medical plan</u> changes online*

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



3 HEALTH BENEFIT CHOICES

To assist with your decision-making, please review the **2024 NYSHIP Choices Guide** and the **2024 ConnectiCare Benefit Plan Summary**, which list all your plan choices. The NYSHIP Choices Guide as well as the ConnectiCare Benefit Plan Summary are 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)**
- **ConnectiCare**

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 health plan enrollment, please submit your request online **OR** complete and submit one (1) of the below forms as applicable:

- **HR-BEN-060K 2024 NYSHIP Open Enrollment/Change Form**
- **HR-BEN-622E 2024 ConnectiCare 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-one (31) 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.

Dental benefits are available to you and your eligible dependents through MetLife, while 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(s) become Medicare-eligible as a result of reaching at least age 65 *or* being disabled upon retirement, 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 Railroad Retirement Board 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.

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 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 wish to *re-enroll* in Medical/Hospital and Prescription Drug Coverage for 2024, you MUST:**
    - Complete the **HR-BEN-060K** 2024 NYSHIP Open Enrollment/Change Form **OR** the **HR-BEN-622E** 2024 ConnectiCare Open Enrollment/Change Form, 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 **HR-BEN-036** Agreement to Decline (Opt-Out) Medical Coverage Non-Represented & Eligible Represented Employees Form, 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. The incentive payments for individual or family plan opt-out will be paid in January 2025 **OR** pursuant to the represented employee's collective bargaining agreement
    - **For 2024, the individual opt-out incentive payment is $1,000**
    - **For 2024, the family opt-out incentive payment is $3,000**

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, the incentive payment will be prorated

4. You have the option to defer the opt-out incentive payment to your 401(k), 457, or Roth accounts
    - 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. If you are a ***non-represented*** employee currently contributing toward your medical coverage, no contributions will be withheld from your 2024 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 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

5 REQUIRED SUPPORTING DOCUMENTATION

To add *new* eligible dependent(s) to your MTA-sponsored coverage, you **MUST** submit **REQUIRED** supporting documentation based on your relationship to the eligible dependent.

1. For a Spouse:

A copy of your marriage certificate as well as a copy of your spouse's birth certificate and social security card are **required**.

AND

If your date of marriage is more than one (1) year old as listed on your marriage certificate, proof of joint ownership is also REQUIRED. If your marriage date is less than 1 year old, proof of joint ownership is not required.

Both the employee's and spouse's names MUST be listed on the documentation of joint ownership. Proof of joint ownership **MUST** be dated within the past 90 days and examples include a copy of:

- Most recent federal or state 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)
    - Only page 1 of the tax return must be submitted
- 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

To *remove* a spouse from your MTA-sponsored coverage due to divorce, you **MUST** submit the first and last page of the divorce decree showing the court filing date.

You are REQUIRED to notify the MTA BSC of your legal divorce within thirty-one (31) days of the divorce date indicated on the divorce decree.

2. For a Domestic Partner:

To enroll a domestic partner into your MTA-sponsored coverage, in addition to the open enrollment form, you **MUST** also complete and submit the domestic partner application package, **HR-BEN-065**, as well as provide all the required supporting documentation listed within the domestic partner application package, to the MTA BSC.

The **HR-BEN-065** package can be obtained on the My MTA Portal *or* by contacting the MTA BSC.

3. For Child(ren):

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.**

6 LEGAL REQUIREMENTS

COVERAGE FOR DEPENDENT CHILDREN

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

- To **enroll** a dependent child, submit the **HR-BEN-060K** 2024 NYSHIP Open Enrollment/Change Form

Submit the form with the required supporting documentation as detailed in Section 5, and affirm, by signing the form, that your child is eligible for MTA-sponsored 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 **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).

7 IMPORTANT TELEPHONE NUMBERS & WEBSITES

Medical/Hospital		
NYSHIP	877-769-7447	http://www.cs.ny.gov
ConnectiCare	860-674-5757 **or** 800-251-7722	www.ConnectiCare.com
Dental		
MetLife	800-942-0854	www.MetLife.com
Vision		
EyeMed	866-299-1358	www.EyeMedVisionCare.com
Tax-Favored Programs		
P&A Group (FSA)	800-688-2611	www.Padmin.com
Prudential/Empower (401K/457 Plans)	877-756-4682	www.Prudential.com/mta
NY 529 College Savings	800-420-8580	www.NY529AtWork.com
HealthEquity/WageWorks (Commuter Benefit)	866-346-5800	www.HealthEquity.com/wageworks
COBRA		
WEX Health, Inc.	866-451-3399	www.WEXInc.com/login
Federal Government		
Medicare	800-633-4227	www.MyMedicare.gov
Railroad Retirement Board (RRB)	877-772-5772	http://www.RRB.gov
Business Service Center		

Phone: 646-376-0123, 8:30a.m. - 5p.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 submitted.

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.

REQUIRED DOCUMENTATION

To Add Dependents and To Maintain Dependent Child(ren) Coverage

I. For Spouse

A copy of Marriage Certificate, Birth Certificate, Social Security card, **AND,** if your date of marriage is more than one year old,

- *Your most recent Tax Return* – Federal or State (including Puerto Rico Returns)
  1. 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).
  2. Only submit page 1 of the return. This could include the 1040 form, e-File Confirmation Page, Tax Preparer's Summary, or Federal Return Recap.
  3. Eliminate all financial information, **OR**

Proof of Joint Ownership

Both the enrollee and spouse's name must be listed on the documentation of joint ownership and be dated within the past 90 days. Examples include a copy of:

- Homeowners/Renters Insurance Policy
- Credit Card Statement
- Loan Obligation
- Bank Account Statement
- Mortgage Statement
- Property Tax Document
- Rental/Lease Agreement
- Utility/phone/internet/cable bills
- Pension/life insurance/will designating spouse as beneficiary

II. 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 or Adoption Certificate
- Social Security Card

III. Dependent Children to age 26

may be eligible for medical benefits under an employee's family coverage.

IV. Dependent Children Coverage ages 19 and 25

Dependent children age 19 to 25, or, if applicable, age as specified in your Collective Bargaining Agreement (CBA) may be eligible for dental and vision care benefits. To enroll or maintain enrollment for your dependent(s) over age 19, and up to age 25 (or per CBA if applicable), for MetLife dental and EyeMed vision benefits coverage, you must provide verifiable proof of your child's full-time student status for each semester.

You may provide proof of full-time status in the form of any of the following: a letter, statement, or documentation from the Bursar or Registrar's office, a printout from the Clearinghouse, or a paid receipt that includes the number of classes/credits.

V. When Dependents Are No Longer Eligible

For a dependent to be eligible for COBRA coverage continuation, your dependent must enroll for COBRA coverage within 60 days of losing coverage (the qualifying event date).

- You must inform the MTA BSC when your dependent is no longer a full-time student. The BSC will update the dependent's status. COBRA Dental and Vision coverage is administered by the WEX Health, Inc.
- WEX Health, Inc. will send you your COBRa notification package.

ConnectiCare, Inc.
P.O. Box 4058, Farmington, CT 06034-4058
www.connecticare.com ■ 1-800-251-7722

Enrollment/Change Form

Please print clearly, complete in full using ballpoint pen.

EMPLOYEE: Complete the following two sections, sign at bottom and read information on reverse side.

Please check appropriate item: ☐ New Enrollment ☐ Terminate Enrollment ☐ Add Dependent ☐ Remove Dependent ☐ Change Physician ☐ Change Division ☐ COBRA Election ☐ Other (Name change, address change, etc. Indicate reason for change.) _____

Plan type: ☐ HMO Open Access ☐ HMO Personal Care Plan ☐ Point-of-Service Open Access Plan ☐ Point-of-Service Personal Care Plan

Employee's Social Security Number	Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Separated ☐ Widowed ☐ Divorced

First Name	Middle Name	Last Name

Street Address	City	State	ZIP Code

Home Telephone Number	Work Telephone Number	E-mail Address (optional)	Primary Language (optional)

MEMBER(S): First Name/Middle Initial/Last Name	Add	Delete	Member Identification Number (existing members only)	Sex	Date of Birth (mm/dd/yy)	Full-Time Student*	Primary Care Physician	Provider ID Number (8 digits)	Existing Patient
Employee	☐	☐	_ _ _ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /			_ _ _ _ _ _ _ _	☐ Yes ☐ No
Spouse	☐	☐	_ _ _ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /			_ _ _ _ _ _ _ _	☐ Yes ☐ No
Dependent 1	☐	☐	_ _ _ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /	☐ Yes ☐ No		_ _ _ _ _ _ _ _	☐ Yes ☐ No
Dependent 2	☐	☐	_ _ _ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /	☐ Yes ☐ No		_ _ _ _ _ _ _ _	☐ Yes ☐ No
Dependent 3	☐	☐	_ _ _ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /	☐ Yes ☐ No		_ _ _ _ _ _ _ _	☐ Yes ☐ No
Dependent 4	☐	☐	_ _ _ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /	☐ Yes ☐ No		_ _ _ _ _ _ _ _	☐ Yes ☐ No

☐ Check if enrolling a disabled dependent age 19 or over and contact ConnectiCare to obtain a form for submitting proof of disability. ***See instructions on back.**

Other health care coverage:
Do you, your spouse or your dependent(s) have other health insurance under a group plan, HMO or Medicare? ☐ Yes ☐ No

If yes, name of person covered	Social Security Number	Employer

Insurance Co. Name and Address (Please attach a copy of your group medical insurance card.)	Policy Number	Medicare (Please attach a copy of your Medicare card.) ☐ Part A ☐ Part B ☐ Retired

EMPLOYER: Complete this section. Form cannot be processed without this information.

COBRA ☐ Yes ☐ No	Length of coverage: ☐ 18 months ☐ 36 months ☐ Other _____	Date of Hire (mm/dd/yy) / /	Coverage Effective Date (mm/dd/yy) / /	Coverage End Date (mm/dd/yy) / /

Group Number/Division	Group Name	Employee Work Location	Plan Description

Employer Signature ▶	Title	Date

Important: By signing here you are indicating that you have read and understand the information on the front **and back** of this form and you agree to keep it confidential. This authorization is valid as long as you are enrolled in a ConnectiCare health plan. I certify that the information supplied in the form is correct. I agree to the consent on the reverse side of this form.

▶ _____

Employee's Signature Date

IMPORTANT: EMPLOYEE/MEMBER CONSENT

On my behalf and on behalf of my spouse and/or dependent(s), I hereby authorize any physician, hospital, provider, insurer, ConnectiCare Inc., (CCI) or a CCI affiliated, or other organization or person having records, data or information concerning health history or medical insurance for me or my family member(s), including but not limited to information concerning mental health, alcohol/substance abuse or HIV or AIDS-related conditions, to transfer to any person or company such records, data or information as may be required for the purpose of providing treatment, paying claims, and performing other operations to administer my Benefit Plan. I understand that CCI's privacy notice contains a more complete description of the purposes for which information about me and my dependent(s) may be used or disclosed and that I have a right to review the privacy notice prior to signing this consent. I understand that CCI may change such notice at any time but will provide me a copy of any amended notice. I understand that I have a right to request restrictions on how information about me and my dependent(s) may be used or disclosed to carry out the plan administration purposes and that CCI is not required to agree to the requested restrictions. I understand that this authorization is valid for the term of my and my dependents' coverage under the Plan. I understand that I can revoke this authorization (but will be terminated from the Plan) at any time by giving written notice to CCI as long as CCI or others have not taken action relying on this authorization. I understand that the pink copy attached is my copy of this authorization. I authorize payroll deduction, if any, for the coverage I have elected.

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime punishable by penalties, imprisonment and restitution depending on applicable laws.

INSTRUCTIONS FOR ENROLLING A FULL-TIME STUDENT DEPENDENT AGE 19 OR OLDER

Please enclose a copy of one of the following documents with your Enrollment/Change Form:

1. **The front and back of a canceled tuition check for the current semester.**
2. **A dated class schedule for the current semester with the student's name on it.**
3. **A paid tuition invoice for the current semester.**
4. **A signed loan agreement for the current semester tuition costs.**

INSTRUCTIONS: DID YOU REMEMBER TO ...

- ☐ **Print clearly, complete all sections and sign at the bottom of page 1?**
- ☐ **Select your primary care physician and include the 8-digit Provider ID number? (Can be found in the Provider Directory or on Web site)**
- ☐ **Attach a copy of your Medicare Card if you are Medicare-eligible?**
- ☐ **Attach a copy of your group medical insurance card if you have other coverage?**
- ☐ **Attach proof of full-time student status?**

Print Form

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