



2024 Open Enrollment

November 1 - December 31, 2023

Health Benefits Summary

**MTA Police
Represented Employees**

MTA Business Service Center
www.mymta.info

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Attachments:

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

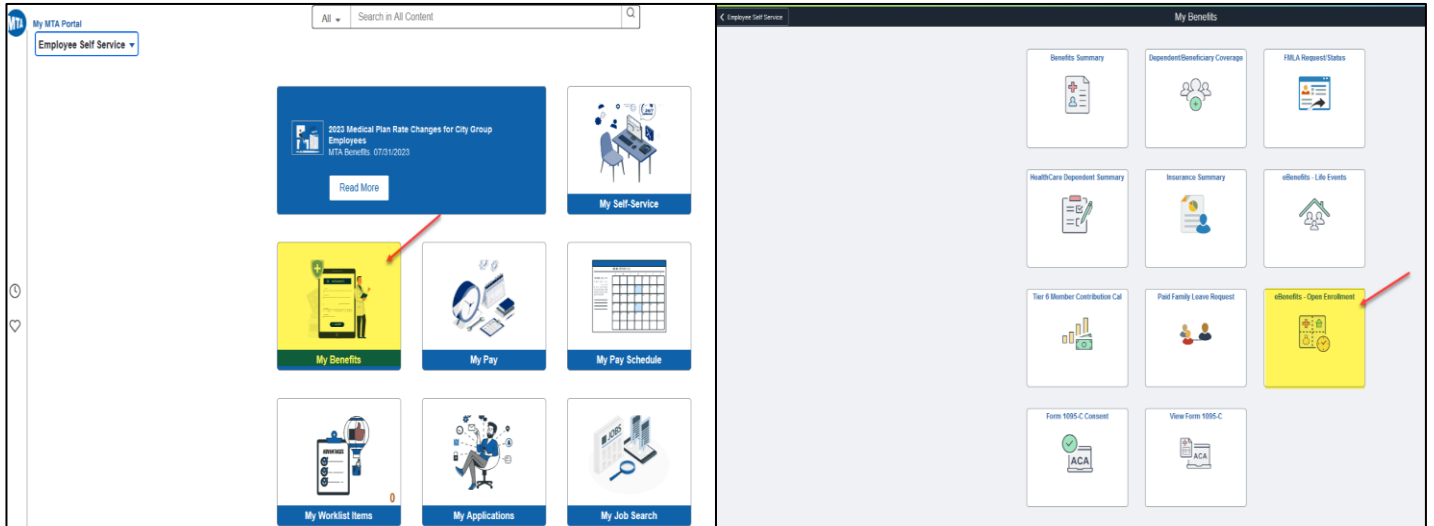
Dates to remember...

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

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

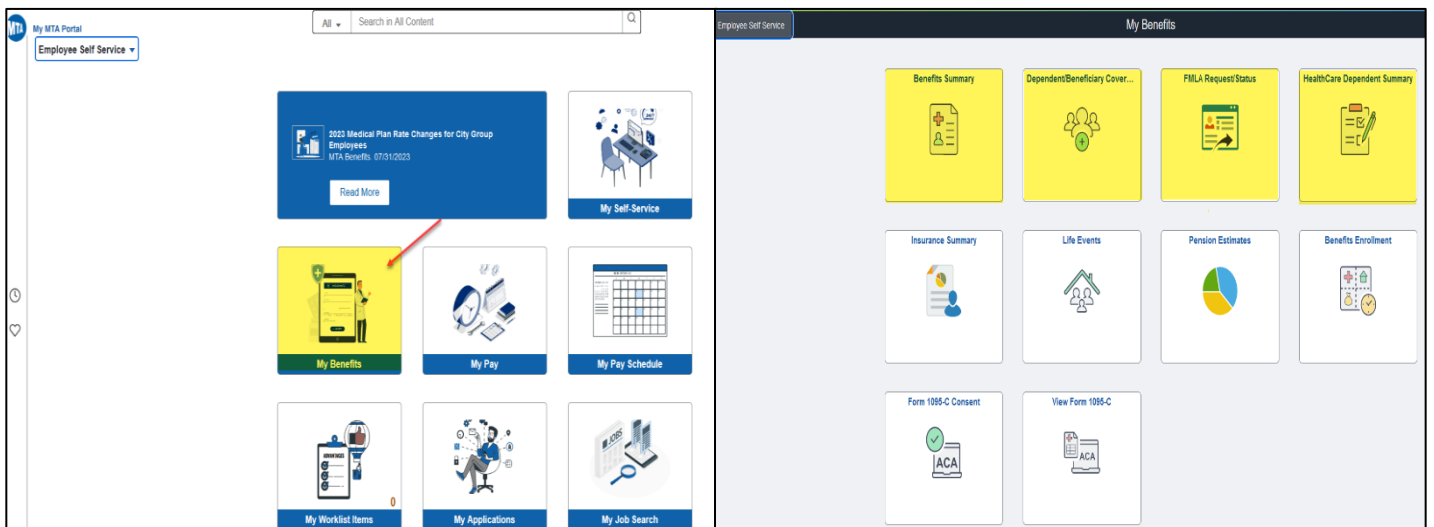
2 HOW TO MAKE CHANGES

- 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 **OR add, remove, or change a dependent**, you must submit the **HR-BEN-060K** 2024 NYSHIP Open Enrollment/Change Form
 - Dependent updates **cannot** be submitted online
 - You **MUST** submit the above form if you would like to add a new dependent or remove or make changes to your current dependent information
 - Do **NOT** use/submit the above form if you are making your medical plan 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](#), which lists all your plan choices. The NYSHIP Choices Guide is available on the 2024 open enrollment website at www.mymta.info/openenrollment.

The [2024 Employee Contribution Rates](#) will be available on the My MTA Portal in December. It will include information on the following options:

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

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

To make changes to your NYSHIP Health Plan enrollment, please submit your request online **OR** complete and submit the below form:

- [HR-BEN-060K 2024 NYSHIP Open Enrollment/Change Form](#)

You may also change your enrollment status/options if you experience a qualifying life event, such as marriage, divorce, birth or adoption of a child, loss of dependent child status, or loss of coverage.

If you experience a qualifying life event, it is important that you update your records by submitting the appropriate forms to the MTA BSC within thirty-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 Social Security Administration in advance so that as a retiree, you and/or your dependent will be enrolled in Medicare Part A (hospitalization) and Medicare Part B (medical) upon retirement.

4 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.**

5 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 4, 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 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).

6 IMPORTANT TELEPHONE NUMBERS & WEBSITES

Medical/Hospital		
NYSHIP	877-769-7447	http://www.cs.ny.gov
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
Social Security Administration	800-772-1213	www.SSA.gov
Business Service Center		
Phone:	646-376-0123, 8:30a.m. - 5p.m., Monday - Friday	
Email:	bscservice@mtabsc.org	
Website:	www.MyMTA.info	
<p><i>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.</i></p>		



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 <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated							Marital Status Date	
11. Covered under Medicare?		<input type="checkbox"/> Self Medicare ID Number: _____ Date: _____						
		<input type="checkbox"/> Dependent Medicare ID Number: _____ Date: _____ Dependent Name: _____						
12. Is any of this information new? <input type="checkbox"/> No <input type="checkbox"/> Yes Box Number(s): _____ Effective Date of Change: _____								

13. ENTER REQUEST(S) BELOW:		
A. Pre-Tax Election		
1. <input type="checkbox"/> 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) <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO Code <input type="text"/> Name _____	
2. Request Family Enrollment <small>(Must complete Box 14 below)</small>	Medical (10) (Select Empire Plan or HMO) <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO Code <input type="text"/> Name _____	
3. Medical Opt-out Program	You can only enroll in the Medical Opt-Out program during the <u>annual Open Enrollment Period</u> . 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)					Date of Event: _____				
ONLY M (Medical) is applicable									
↓	↓	Last Name	First Name	MI	Relationship	Date of Birth	Gender	Address (if different)	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C	<input type="checkbox"/> M						<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> X		
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C	<input type="checkbox"/> M						<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> X		
<input type="checkbox"/> A <input type="checkbox"/> D <input type="checkbox"/> C	<input type="checkbox"/> M						<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> 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 Divorce
 Domestic Partner Termination of Domestic Partnership (Attach completed PS-425.4)
 Newborn Only dependent ineligible due to age
 Request coverage for dependents not previously covered I voluntarily cancel coverage for my dependents
 Previous coverage terminated (proof required) Only dependent died
 Dependent returned to full-time student status 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		Date Entered on NYBEAS	Effective Date
		# Hours	Hourly Rate of Pay		

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 updated 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 12239Instructions 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).
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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 <u>Decline</u> coverage if you are a newly hired employee <u>OR</u> promoted into an eligible role/title. Due to a qualifying life event <u>OR</u> during your respective open enrollment period, you are eligible to voluntarily <u>Cancel</u> your current enrollment/coverage.

AUTHORIZATION	You must SIGN and DATE this form.
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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
- Pension/life insurance/will designating spouse as beneficiary
- Mortgage Statement
- Property Tax Document
- Rental/Lease Agreement
- Utility/phone/internet/cable bills

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.