2023 Open Enrollment
November 1 - December 31, 2022
Health Benefits Summary

MTA Police
Represented Employees

MTA Business Service Center
www.mymta.info

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Attachments:
- HR-BEN-060K 2023 NYSHIP Open Enrollment/Change Form
- HR-BEN-600 Dependent Change Request Form

1 INTRODUCTION

Open Enrollment Period: November 1 - December 31

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

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.

- 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-060K** 2023 NYSHIP Open Enrollment/Change Form
  - *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

To assist with your decision-making, please review the **2023 NYSHIP Choices Guide**, which lists all your plan choices. The NYSHIP Choices Guide is available on the 2023 open enrollment website at www.mymta.info/openenrollment.

The **2023 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, 2022 open enrollment deadline, except if the option you are enrolled in no longer services the area in which you live.

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

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

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. This will occur on the first of the month coincident with your retirement date or the following month.

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 LEGAL REQUIREMENTS

Coverage for Dependent Children Ages 19 to 26

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

- To enroll a dependent child, age 19 to 26, submit the **HR-BEN-060K 2023 NYSHIP Open Enrollment/Change** form

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

Submit the applicable form above, 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 the 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 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.

5 IMPORTANT TELEPHONE NUMBERS & WEBSITES

Medical/Hospital		
NYSHIP	877-769-7447	www.cs.ny.gov
Dental		
MetLife	800-942-0854	www.metlife.com
Vision		
EyeMed	800-334-7591	www.eyemedvisioncare.com
Tax-Favored Programs		
P&A Group (FSA)	800-688-2611	www.padmin.com
Prudential (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
Government		
Medicare	800-633-4227	www.MyMedicare.gov
Social Security Administration	800-772-1213	www.ssa.gov
Business Service Center		
Phone: 646-376-0123, 8:30 a.m. - 5 p.m., Monday – Friday Email: bscservice@mtabsc.org Website: www.mymta.info Fax: 212-852-8700 ***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.***		

Department of Civil Service
Albany, NY 12239

NYSHIP Program Information Resources

To enroll in benefits or to change your current benefits, you will most likely be required to submit proofs of eligibility for coverage or evidence of a qualifying event with the completed and signed *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.

Boxes 1 – 11	Employee Information	You must complete boxes 1 – 11 with your personal information. **Note:** Use the Marital Status Date to show the date of marriage, separation or divorce when any of those marital statuses are selected.
Boxes 12 (A-B)	Elect or Change Coverage	Complete the appropriate sections. You can only select one (1) option between available options 1, 2, or 3 in Section B. To participate in the Medical Opt-Out Program, please do **NOT** complete or submit this form. Instead, you **must** complete the **HR-BEN-036 Agreement to Decline (Opt-Out) Medical Coverage Non-Represented and Eligible Represented Employees** form or visit My MTA Portal at www.mymta.info to quickly and easily opt-out online.

12.A.1 12.A.2	Pre-Tax Contribution Program (PTCP) Status	The PTCP applies to all NYS groups and select Participating Employers (PE).
12.B.1	Request Individual Enrollment	Check box to enroll in Individual coverage.
12.B.2	Request Family Enrollment	Check box to enroll in Family coverage.
12.B.3	Medical Opt-Out Program	To participate in the Medical Opt-Out Program, do **NOT** complete this form. Instead, you **MUST** visit My MTA Portal to opt-out online OR complete the HR-BEN-036 Opt-Out form.

Department of Civil Service
Albany, NY 12239

Instructions for NYSHIP Health Insurance Transaction Form
PS-404 (12/2021)

Box 13.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 13.B	Voluntarily Decline or Cancel Coverage	You are entitled to voluntarily decline coverage if newly hired or promoted into an eligible role/title. As a result of a qualifying life event OR during your appropriate open enrollment period, you are able to voluntarily cancel your coverage.

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).

AUTHORIZATION	You must SIGN and DATE this form.

Department of Civil Service

EMPLOYEE BENEFITS DIVISION
NYSHIP Health Insurance Transaction Form
for Participating Employer (PE) Employees

PS-404 (12/2021)

INSTRUCTIONS: READ AND COMPLETE BOTH SIDES/PAGES. PLEASE PRINT AND CHECK THE APPROPRIATE CHOICES.

EMPLOYEE INFORMATION *(All employees must complete)*			
1. Last Name First Name MI	**2.** Social Security Number	**3.** Sex ☐ Male ☐ Female	
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: ☐ Yes ☐ No	Spouse/Domestic Partner: ☐ Yes ☐ No	Child: ☐ Yes ☐ No	

12. ENTER REQUEST(S) BELOW	
A. Pre-Tax Election	
1. ☐ **Elect Pre-Tax Status** for Premium deduction	
B. Elect or Change to a NYSHIP Coverage Option Below (You can only choose one option between either 1, 2, or 3)	
1. Request Individual Enrollment	Medical *(10)* *(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO Code ____ Name ______________
2. Request Family Enrollment *(Must complete Box 14 on Page 2)*	Medical *(10)* *(Select Empire Plan or HMO)* ☐ Empire Plan ☐ HMO Code ____ Name ______________
3. Medical Opt-Out Program *(Only for those enrolled in the Pilot Program)*	If interested in participating in the Medical Opt-Out Program, do NOT complete this form. You must instead 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 online**.

13. ENTER REQUEST(S) BELOW

A. Elect or Change Coverage: ☐ Medical *(10)* **Date of Event:**____________

☐ **Elect/Change to FAMILY Coverage** *(Must complete Box 14 on Page 2)* ☐ **Elect/Change to INDIVIDUAL Coverage**

☐ Marriage	☐ Divorce
☐ Domestic Partner	☐ Termination of Domestic Partnership
☐ 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 married
	☐ Only dependent graduated
☐ Other: __________________	☐ 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 & would like to voluntarily cancel your coverage, please indicate the qualifying event above.)

Department of Civil Service
Albany, NY 12239

NYSHIP Health Insurance Transaction Form
PS-404 (12/2021)

14.		DEPENDENT INFORMATION					
MUST be provided when choosing to enroll or opt-out of 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	Sex	Address *(if different)*	Social Security Number
☐ A ☐ D ☐ C	☐ M						
☐ A ☐ D ☐ C	☐ M						
☐ A ☐ D ☐ C	☐ M						
☐ A ☐ D ☐ C	☐ M						

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:**

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.